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ABSTRACT

Findings from a national study of early intervention programs and toy libraries for handicapped children in Australia are summarized. After an introduction to theoretical concerns, chapter 2 reviews the rationale for early intervention and describes research on components of exemplary programs and on evaluation of the effectiveness of early intervention. Data collection procedures (site visits and questionnaires) are described. Summaries of the pattern of intervention in states and territories are presented for New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, Northern Territory, and the Australian Capital Territory. The fifth chapter analyzes intervention approaches in terms of models, sponsorship, orientation, target population, and staffing patterns. Statistical information, gathered from questionnaires submitted by the directors of early intervention programs which met the study's definitional criteria, is also presented. A review of parent responses identifies areas of concern and unmet needs. Two chapters address the importance of play and the contributions of toy library services. A final chapter presents the report's conclusions on the concept and nature of early intervention; program issues (such as assessment and program monitoring); the service delivery system; and ongoing research and evaluation. Fifteen appendixes include sample questionnaires and the site visit interview/observation guide. (CL)

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Department of Social Security

EARLY INTERVENTION PROGRAMS
FOR YOUNG HANDICAPPED CHILDREN IN AUSTRALIA
1979-80

Fred and Eleanor Schonell Educational Research Centre
Department of Education, University of Queensland

August 1981

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This publication is one of a trilogy of reports which together represent a series of interrelated research programs on early intervention with young handicapped children undertaken by the Fred and Eleanor Schonell Educational Research Centre.

The three reports are:

Watts, B.H., Elkins, J., Conrad, L., Andrews, R.J., Apelt, W.C., Hayes, A., Calder, J., Coulston, A.J., Willis, M., 1981: *Early Intervention Programs for Young Handicapped Children in Australia, 1979-1980.*

Elkins, J., Calder, J., Conrad, L., Shepherd, J., Coulston, A., Willis, M., 1980: *Toy Libraries in Australia: A Report with Special Attention to Their Role in Services for Young Handicapped Children and Their Families.*

Hayes, A., Steinberg, M., Cooksley, E., Jobling, A., Best, D., Coulston, A., 1981: *Special Preschools: Monitoring a Pilot Project.*

The first two studies were commissioned by the Office of Child Care of the Department of Social Security. The third was undertaken at the request of the Queensland Department of Education and funded by the Office of Child Care.

It is the hope of the staff of the Fred and Eleanor Schonell Educational Research Centre that these studies will aid the development of further insights into the nature and needs of young children with disabilities and their families and the ways in which account must be taken of the complex ecologies within which early intervention programs grow and develop.

B.H. Watts
Professor of Special Education and Director
Fred and Eleanor Schonell Educational Research Centre

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PARTICIPATION IN THE STUDY

In completing this review of early intervention programs in Australia, all of the academic staff* of the Fred and Eleanor Schonell Educational Research Centre at the University of Queensland were involved, together with the research staff* appointed for the project. Particular staff members, however, had primary responsibility in accomplishing the following major tasks.

Conceptualization and development of the theoretical framework. All staff of the Fred and Eleanor Schonell Educational Research Centre participated in the ongoing process of conceptualizing the study and in modifying, as required, the research program. Miss W.C. Apelt was most actively involved in a wide-ranging study of early intervention theory and practice. Dr J. Calder spent much time on the study of concepts of play which informed the observations of children in early intervention and laboratory settings. Various members of the staff were instrumental in collecting, reading, and assessing the relevant literature. For example, Ms P. O'Brien, an ERDC Fellow at the Fred and Eleanor Schonell Educational Research Centre, reviewed materials used in early intervention programs, and Mrs M. Steinberg, Ms J. Shepherd, and Ms L. Conrad reviewed recent material on evaluation.

Field study. The field study included visits to early intervention programs in all states, permitting discussion with staff and parents, interviews with representatives of government departments and agencies in each state, and meetings with parents. Dr J. Elkins, Ms L. Conrad, Dr J. Calder, Ms M. Willis and Ms J. Shepherd played the major role in the field study, with the assistance of Mrs E. Cooksley. Mrs P. Gunn and Ms P. O.Brien supplemented this work by meeting with parents seeking the establishment of early intervention programs.

Observations of a sample of children. These observations, carried out in laboratory and early intervention settings, were made primarily by Mrs P. Gunn with assistance in testing of children from Dr P. Berry and Ms J. Shepherd.

Analysis of data. Analysis of data from site visits was carried out primarily by Dr J. Elkins, Ms L. Conrad, Ms M. Willis, Dr A. Hayes, Dr J. Calder and Ms J. Shepherd. Mr A. Coulston was the principal analyst of questionnaire data. Mr A. Coulston was helped by coders: Mrs J. de Jersey, Mrs L. Gunn, Ms N. Arcidiacono, Mrs A. Jobling, and Ms N. Hardy.

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* Academic staff members: Professor B.H.Watts,(Director),Dr R.J.Andrews, Ms W.C.Apelt, Ms J.K.Atkinson, Dr P.B.Berry, Mrs K.J.Cochrane, Dr J.Elkins, Dr A.Hayes. Research staff members: Ms L.Conrad (Project Coordinator), Dr J.Calder, Mr A.Coulston, Mrs P.Gunn, Ms J.Shepherd; Ms M.Willis.

Workshops. In reporting preliminary findings and encouraging discussion at workshops held in each state, Professor B.H. Watts, Dr R.J. Andrews, Dr J. Elkins, Ms L. Conrad, and Dr J. Calder played a major role. Other participants in workshops were Dr A. Hayes, Ms J. Shepherd, Ms W.C. Apelt, and Mrs P. Gunn. In preparation for the workshops, Ms J.K. Atkinson compiled glossaries and reading lists for parents. Ms P. O'Brien reviewed early intervention resource materials, and her reviews were edited by Ms S. Ritter.

Completion of the report. In addition to the authors cited in the report, other members of the staff made significant contributions, assisting in the discussion of issues and reviewing draft chapters. The text in draft and final form was typed by Mrs R. Ganzini-Falzone, Mrs B. Sockhill and Mrs J. McCormack. Mr P. Fong assisted with administrative arrangements throughout the period of the research project.

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CHAPTER 1

INTRODUCTION

As part of its contribution to the International Year of the Child, the Office of Child Care of the Department of Social Security commissioned the Fred and Eleanor Schonell Educational Research Centre to undertake a national study of early intervention programs and toy libraries for handicapped children. The study, begun in 1979, was intended to provide a comprehensive survey of such programs, including not only those funded by the Office of Child Care, but also those funded from other sources both governmental and non-governmental.

The aims of the project were :

(1) to undertake a literature review of theory and practice in early intervention;

(2) to identify and describe early intervention programs in Australia directed towards the development of young handicapped children and the support of their families;

(3) to study play in relation to early intervention;

(4) to evaluate the concept of toy library services and the role of such services in helping handicapped children; *

(5) to review the role of early intervention programs in Australian services to the handicapped; and

(6) to disseminate the findings of the project on a national basis, stimulating discussion among parents and program staff.

We planned, through the study, to provide information of use to several groups:

- service groups providing now, or likely to provide in the future, early intervention and toy library services to handicapped children;
- parents seeking assistance in fostering the development of their handicapped children;
- governmental bodies (especially the Office of Child Care) requiring information useful for the formulation of funding policies; and
- agencies seeking to determine their role within the total pattern of service provision for young handicapped children and their families.

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* See Elkins, J., Calder, J., Conrad, L., Shepherd, J., Coulston, A., and Willis, M. (1980). (Appendix M).

The theoretical and analytical aspects of the project involved a search of relevant literature, a review of the theories underlying early intervention and the nature of a range of programs, and an exploration of early intervention research. This aspect of the study was intended to provide a conceptual framework for the study of the concept of intervention, recent applications of which have attempted to compensate for cultural and economic differences or deficiencies, to provide alternatives to supplement the home care of handicapped children, and to remediate the effects of delayed development in children with disabilities.

The study in its observational and descriptive aspect focussed on a number of programs in each state which were site-visited and a larger number on which details were obtained through a mailed questionnaire. We sought an understanding of the programs through the eyes of both staff and parents. A small sample of handicapped children at play in a number of settings was also studied.

Our understanding of the nature and perceived adequacy of early intervention programs in Australia was aided considerably through interchanges and discussions with parents and program staff at workshops which were held in each capital city. At these workshops there was extensive discussion of a wide range of issues, some of which had been identified by our research team and others by parents and/or program staff as significant and, in many respects, problematic.

The approach to evaluation followed throughout this study is discussed in Chapters 2, 3 and 9. Briefly, it recognizes the evolutionary nature both of early intervention programs and of concepts of evaluation. Bronfenbrenner (1977) has described the former as evolving entities embedded in the ecology of human development. Viewed in this light, program evolution can be seen as the product of changes in the wider community (particularly its attitudes and values and hence in the resources for which it provides support), in the network of service delivery systems, in the families and their perceived needs and in program staff; we have sought to understand this evolution and to document program characteristics at the close of the '70s.

Anderson and Ball (1978) underscore the emergent nature of evaluation and the fact that many central questions remain contentious. They list the following six major purposes:

(1) to contribute to decisions about program adoption,

(2) to contribute to decisions about program continuation, expansion or certification,

(3) to contribute to decisions about program modification,

(4) to obtain evidence to support a program,

(5) to obtain evidence to rally opposition to a program, and

(6) to contribute to understanding of basic psychological, social and other processes.

It is clear that all of these purposes have relevance to the research study reported here, yet completion of a major task was required before such purposes could be addressed; this was the compiling of a map of the current early intervention scene in Australia. Such a map is provided by this study, together with discussion of both context and program variables.

CHAPTER 2

THEORETICAL CONCERNS

W.C. Apelt

INTRODUCTION

The past two decades have witnessed an unprecedented upsurge of interest in early childhood development and particularly in the provision of intervention programs for young children and infants at risk for delayed or abnormal development. This vulnerable population includes: children with organically based mental, physical and sensory handicaps; those at risk for a wide spectrum of developmental disabilities as a result of gestational and peri-natal trauma; and those whose developmental integrity is threatened by adverse environmental and socio-economic circumstances. These categories of biological and socio-cultural risk are not mutually exclusive (Tjossem, 1976). Sameroff and Chandler (1975), for instance, have demonstrated quite conclusively that the quality of the care-taking environment that the child subsequently encounters tends to amplify or attenuate the impact of neurological insult associated with conditions such as low birth weight, prematurity and perinatal anoxia. This interaction follows a social class gradient, placing biologically vulnerable children from the lowest socio-economic groups in double jeopardy.

2.1
MODELS OF CHILD DEVELOPMENT

Clarke and Clarke (1976) claim that

> ... although there is at the present time no clearly formulated model of child development, nor ... has empirical research advanced sufficiently to build one, there is a growing consensus that ultimately such a model must take account of discontinuities as well as continuities, the child as an active agent in social transactions, and the potentiality for modification of behaviour patterns within the limits set by constitutional factors (Kagan & Klein, 1973; Clarke & Clarke, 1976;Schaffer, 1976; Sameroff & Chandler, 1975). pp. 269-270.

Previous models such as the Main Effect and Interactional Models have proved inadequate to the task of elucidating the complex processes involved in child growth and development. The Main Effect model holds that both constitutional and environmental factors exert independent influences on child outcomes. A defective constitution results in a particular effect irrespective of the operation of differential environmental factors. A pathological environment bears the sole responsibility for a damaged individual, regardless of constitutional variations. With the exception of extreme cases of constitutional or environmental pathology, there is clear empirical and clinical evidence against this model (Sameroff & Chandler, 1975).

While the Interactional Model more easily accounts for research findings which support the interaction between environmental and constitutional factors, it has difficulty in identifying causal mechanisms leading to developmental anomalies. In particular, the assumption that both nature and nurture are "elements whose structure is constant over time" (Sameroff, 1975, p. 67) seems unwarranted.

Sameroff claims that only a model which can accommodate the diversity of effects to be found between and within constitutional and environmental variables is capable of dealing with both the processes and the outcomes of development. Adopting an organismic approach to the interpretation of developmental phenomena, Sameroff and Chandler (1975) emphasize the need for a transactional model in which contact between organism and environment results in their mutual alteration. This model has gained wide acceptance. Anastasiow (1981), for example, endorses

> ... a perspective that emphasizes children as the source of learning in an environment that either facilitates or impedes growth. The scenario is a transactional one in which the child influences and is influenced by the environment itself or the agent of the environment (usually the mother).
>
> ... child, caregiver, and physical environment comprise a transactional network in which no one element can be left out. (p. 277).

2.2
THE ROLE OF EARLY EXPERIENCE

The belief that early experience makes a crucial and disproportionate contribution to later growth and development is deeply entrenched in Western thought (Clarke & Clarke, 1976; Leiderman, 1978). This view of man and his development has enjoyed widespread currency from the time of Plato to the present day. Tjossem (1976) writes -

> ... Infancy and the first 2 years of life provide the foundation upon which the cognitive, social, and biological performance of the school age child moving to adulthood is formed. (xxiii).

Stedman (1977) also endorses this view -

> ... The effects of a stimulating or depriving environment appear to be most powerful in the early years of childhood when the most rapid growth and development take place. (p. 100).

The early experience model of child development has not gone unchallenged. There is a growing number of theorists who espouse a life span developmental orientation which holds that -

> ... the degree to which early experiences continue to influence subsequent development depends upon the mechanisms ensuring the continuities of those early experiences (Zigler, 1977) as well as the potency of the environment in which the individual is currently functioning (Kagan & Klein, 1973). (Goldhaber, 1979, p. 119)

The early experience and the life span orientations are not antithetical. Clarke & Clarke (1976), for instance, affirm their belief in the importance of early experience, but as one link in a developmental chain in which continuing and later experiences make significant contributions to developmental outcomes.

A comprehensive and articulated analysis of the role of early experience within a life span framework has been undertaken by the Clarkes. (Clarke,1968; Clarke & Clarke, 1972; Clarke & Clarke, 1976; Clarke, Clarke & Reiman, 1958).

Their work examines issues such as critical periods in early development, the long term durability of early experiences, the reversibility of early trauma and the relevance of animal research on the effects of early experience (Goldhaber, 1979).

The most contentious of these issues is the notion of critical periods. This concept, which originated in the physical and biological sciences, has been extended to include the study of human behaviour (Leiderman, 1978).

From a biological perspective the critical importance of early experience resides in the plasticity of the central nervous system in the early years when very rapid development takes place. In elaborating the concept of plasticity, Lipton (1976) claims that there are critical periods for exposure to appropriate experiences. These critical periods

> ... exist whenever the biological substrates of a psychological structure reach an appropriate age and stage of receptivity. At that stage, specific environmental experiences are requisites for the development of specific behavioural capacities. (p. 71)

Critical periods may be very brief or prolonged, and the timing of exposure must take account of maturational factors. Too early provision ignores the organism's developmental immaturity and limited response capabilities. On the other hand, failure to provide experiences at the appropriate time may result in irreversible loss of the behavioural potential.

Clarke and Clarke (1976) reviewed both experimental animal studies, upon which the notion of critical periods heavily relies, and studies of children in naturally occurring circumstances of extreme isolation or deprivation. These researchers concluded that -

1. The notion of a critical period of development exercising a powerful influence on later characteristics does not accord with some evidence of the development of deprived children, and particularly of those who had experienced significant environmental change;

2. normally, and for most children, environmental change does not occur, so in later life one may be looking at the outcome, not merely of early experience, but of continuing experience;

3. experimental studies of extreme deprivation in animals, while important, must for a number of reasons be regarded with caution before extrapolation of these findings to humans; and

4. important experiments on reversing the effects of early experience in animals remain to be carried out.

(Clarke & Clarke, 1976, p.12)

2.3
THE RATIONALE FOR EARLY INTERVENTION

Evans (1975) argues that the view of childhood which emphasizes the overriding importance of the early years in determining the course of development rests upon five basic assumptions. These assumptions constitute the rationale for the provision of early intervention programs for children at risk because of environmental inadequacies.

1. Children are, by nature, malleable and their growth and development can be modified extensively in a variety of directions.

2. The earlier one can effect a plausible intervention, the better.

3. The manipulation of early experience will influence subsequent psychological functioning. This influence can be salutary or hindering. In either case cumulative development is involved.

4. The provision of qualitatively sound experience can mollify or compensate for basic lacks in the child's environments. Such lacks define the basis on which experiences can be built. Furthermore, since the school's scholastic emphasis demands certain learning capabilities, such capabilities must become the focus of early intervention.

5. Children who fail to reap the benefits of planned intervention are likely to develop in ways that are counter-productive to extant social-educational conditions. Or since a high level capacity for symbolic (cognitive) activity is one of man's greatest strengths, children who manifest disorders in cognitive performance are failing to achieve their human potential. Thus resources must be marshalled to prevent or remediate these disorders. (p. 6)

Psychological research on the long-term influence of early experience on human subjects has traditionally used two data sources, the reversibility of early developmental trauma, and the long-term stability of early personality characteristics (Goldhaber, 1979)

2.3.1
Early Developmental Trauma

Early developmental trauma may be operationally defined either in terms of biomedical factors associated with gestational and birth processes such as low birth weight, prematurity or perinatal anoxia, or in terms of grossly aberrant caretaking and environmental inadequacies.

Biomedical factors

In an influential review of the literature on potentially damaging neonatal characteristics, Sameroff and Chandler (1975) failed to substantiate any consistent relationship between early risk factors and subsequent developmental status. The indicators of neurological damage in anoxic infants, for instance, present both at birth and at age three, no longer differentiated these children from a non-anoxic control group four years later. The most powerful indicator of differential outcomes was social class. Social class, however, is a composite variable which subsumes such diverse components as nutrition, access to medical services and health care, a range of linguistic, cognitive and motivational models and variations in the provision of enriching experiences.

The most optimistic finding to emerge from this review was -

> ... the self-righting tendency which appears to move children towards normality in face of the pressure towards deviation (p. 236).

This self-righting tendency is maximally operative in nurturant and supportive environments.

Gross environmental deprivation

The early research into the effects of grossly depriving environments on children's physical, intellectual and emotional development reported extremely discouraging findings (Spitz, 1945; Goldfarb, 1955; Bowlby, 1951 ; Dennis & Najarian, 1957).

Disruption of mother-child relationships and child-rearing practices in sub-standard institutions, which frequently involved sensory under-stimulation and social unresponsiveness, were associated with gross developmental retardation, mental deficiency, behavioural anomalies and sociopathic personality. The processes implicated in this failure to thrive were not clearly understood; it was assumed, nevertheless, that these negative consequences were irreversible.

Early stimulation

While the early deprivation studies painted a very pessimistic picture of the possibility of recovery from early trauma, the pioneering work on early stimulation by Skeels and Dye (1939), Kirk (1958) and Klaus and Gray

(1968) indicated a much more favourable prognosis. Radical environmental change, involving intensive and prolonged social stimulation and experiential enrichment, could effect dramatic improvement in the intellectual functioning and behavioural responses of children previously at dire risk for permanent status as mentally retarded.

This research, which demonstrated, among other findings, that enriched early environments were associated with substantial initial gains in IQ, gave impetus to the massive Head Start program directed at improving the life chances of pre-school socially disadvantaged children. The major goal was to circumvent or reverse the cumulative intellectual and academic retardation which was characteristic of the children of socially and economically deprived minority groups. The Head Start program was one of the major initiatives in the United States during the decade of the sixties, to counteract the devastating effects of poverty and it reflected the prevailing sociopolitical Zeitgeist.

This vast program of social action was accompanied by several influential research studies designed to assess both the immediate and long-term impact of different program models (Bereiter & Engelmann, 1966; Karnes, 1969; Hodges, McCandless & Spicker, 1967). The most widely publicized of these intervention programs was the now famous Milwaukee Project (Heber & Garber, 1975).

The epidemiological studies which preceded this project revealed that retardation was not randomly distributed in socially and economically impoverished environments, but was heavily concentrated in clusters of slum families characterized by low parental intelligence. The Heber and Garber study represents a massive longitudinal attempt at rehabilitation of families trapped in the cycle of retardation associated with poverty and social disadvantage.

Children in the experimental group participated in a daily program of intensive sensory, perceptual, motivational and cognitive stimulation extending from early infancy to school entry. Children in the control group were tested at regular intervals, but neither they nor their families received any of the experimental treatments. Intervention included rigorous efforts to modify the family environment. Mothers received training in literacy skills, home-making and child care, supplemented by rehabilitation services in the form of occupational training and placement. By the end of the experiment there was a significant mean difference of thirty IQ points between experimental and control groups; in addition, the experimental subjects displayed superiority on a wide range of measures designed to assess the outcomes of the different program components, such as perceptual, motivational and linguistic skills.

Follow-up testing has confirmed the maintenance of a significant difference between the groups in mean IQ, although the intellectual status of both groups has deteriorated. Children in the experimental group, however, are still operating within the normal IQ range, while their control counterparts are approaching retarded status. Heber and Garber have also reported that the experimental children experienced some adjustment problems upon their admission to the regular school system. This behavioural consequence is probably related to the withdrawal of intensive support at this stage.

This study has been criticized for methodological inadequacies which either raise questions concerning the validity of the results, or which make replication impossible because of inadequate treatment specification (Page, 1973). In addition, Clarke and Clarke (1976), in the light of evidence concerning the temporary nature of IQ gains manifested during early intervention, question whether the program continued long enough to prevent the erosion of positive effects after return to the ghetto environment and the withdrawal of massive support services. Only longitudinal evaluation can answer these questions, although already there is some support for the Clarkes' hypotheses.

Despite its inadequacies, the Heber project must be acknowledged for its pioneering contribution in the field of early intervention. This study represents the first prospective approach to the prevention of cultural-familial retardation.

Further experimental studies such as the Abecedarian Project (Ramey *et al.*, 1976), which is a longitudinal and multi-disciplinary attempt to prevent developmental retardation, should provide data on the specific contribution of the early stimulation program, which the Milwaukee Project failed to do.

2.4
CHARACTERISTICS OF EXEMPLARY PROGRAMS

Karnes (1975) reviewed both early education programs for the handicapped and the findings of research-based programs for the disadvantaged. She identified characteristics which distinguished exemplary programs. Although not all components are included in all programs, several are found in all exemplary programs. The most important components appear to be early identification, including attempts to locate the less visible mildly to moderately handicapped young child; selection of an appropriate model of service provision, either home, home and centre or centre-based; well-defined instructional models to organize the program; a positive approach, with plans and procedures based on goals that are realistic, concrete and comprehensible to professionals and parents alike; strong parent involvement; inter- and trans-disciplinary approaches, under strong leadership; ongoing internal and external evaluation with effective feedback; and programs which place a strong emphasis on language development (Karnes & Zehrbach, 1977).

2.5
EVALUATION OF THE EFFECTIVENESS OF EARLY INTERVENTION PROGRAMS

2.5.1
Socially Disadvantaged Children

Comprehensive evaluations of the short and long term effectiveness of early intervention with socially disadvantaged children have been undertaken by Bronfenbrenner (1974) and Stedman (1977). In order to introduce a measure of scientific rigour into his review, Bronfenbrenner (1974) restricted his analysis to programs which met the following experimental criteria: random allocation of children to experimental and control groups, comparability of criterion measures, and the availability of follow-up data. Five group pre-school and two individually administered home-based programs were examined.

The children in the group pre-school programs ranged between three and five years of age. The programs varied from 'traditional' pre-school content with no special enrichment features, to specially prescribed developmental and remedial programs.

The data revealed that pre-school intervention produced substantial gain in IQ during the operation of the program. Further IQ gains did not occur when programs were extended beyond one year. More critically, positive effects tended to dissipate after termination of the intervention, with this trend becoming more pronounced the more extended the follow up. Participation of children in group programs before the age of three did not yield more favourable long-term intellectual outcomes.

Data comparing the effectiveness of different types of pre-school programs suggested that the greatest and most enduring IQ gains resulted from structured programs with a strong verbal and cognitive emphasis, but even these programs exhibited erosion of gain scores at follow up.

A different picture emerged from the data on home-based programs. The substantial initial gains of the experimental groups not only improved but persisted three to four years after intervention ceased. The most successful programs were those in which the major focus was enhancement of the mother's primary and continuing role in the teaching process. The earlier and the more intensely mother and child were stimulated to engage in reciprocal interactions around a cognitively challenging activity, the greater and more enduring was the gain in IQ achieved by the child (Levenstein, 1970; Karnes & Badger, 1969).

These home-based programs were undertaken with one to three year old children and involved home visits by tutors (Toy Demonstrators) whose primary concern was to facilitate parent-child interaction as the basis for developing verbal and conceptual skills.

Stedman's evaluation yielded very similar findings.

In summary, investigations of the effectiveness of early education for socially disadvantaged children suggest that intervention will produce the most favourable immediate and long-term gains in intellectual status when -

(1) the intervention begins very early, before the age of two;

(2) parents are trained in order to enhance their teaching role in the home; and

(3) high priority is given to the development of language and cognitive skills within a structured program.

Faced with the discouraging findings concerning the long-term outcomes of group intervention, some researchers turned their attention to the experimental investigation of different program models.

Miller and Dyer (1974), for instance, undertook a comparison of four pre-school programs, Bereiter - Engelman , DARCEE, Montessori and Traditional, with a follow up extending through to the third year of school attendance. A major purpose of the study was to assess differential program effects, in both the short and long term, on the cognitive, motivational and perceptual development of young disadvantaged children. Miller and Dyer found that the programs did produce different effects, both in terms of immediate impact, and over a four year period. This latter result was found irrespective of the programs the children subsequently experienced. Immediate effects on cognitive variables were greater for more didactic programs, but more stable effects were found in non-cognitive areas.

2.5.2
Biologically Impaired Children

Examination of the growing literature on early intervention programs for handicapped children discloses that while the major thrust has been directed towards socially disadvantaged children, many exemplary programs have been devised and implemented for infants and young children who are biologically impaired. These programs encompass a broad spectrum of handicap: the blind (Fraiberg, Smith & Adelson, 1969; Fraiberg, 1971); the auditorily-impaired (Horton, 1976); the cerebral palsied and multiply-handicapped (Barrera et al., 1976; Haynes, 1976); and children with Down's syndrome (Hayden & Dmitriev, 1975; Rynders & Horrobin, 1975).

Most of these programs, while they cater for the child's whole range of developmental needs, employ goals and strategies focal to the child's particular handicap. Recognizing that physical, sensory, and intellectual handicaps constitute barriers to full participation in the opportunities for learning provided by the environment, most programs also include a focus on experiential enrichment.

Despite the dearth of empirical evidence concerning their effectiveness, there appears to be general consensus, largely based on value judgments, that intervention programs for biologically impaired infants and young children both enhance the development of the child and provide guidance and support to the family. In many infant programs, the family, particularly the mother with professional support, becomes the principal change agent. Levitt and Cohen (1975) reviewed representative parent-intervention programs for mentally and physically handicapped infants and young children. Thirteen programs for handicapped children spanning the years 1961-1972 are included in their analysis.

Their survey of evaluation measures and treatment outcomes showed that widely differing criteria ranging from subjective impressions to standardized test scores were used in evaluating efficacy of the programs. Seven of the programs used no statistical measures, and outcomes were stated in generalized subjective terms.

2.6
TOWARDS A DEVELOPMENTAL PERSPECTIVE : THE NATURE OF DEVELOPMENTAL CHANGE AND THE EVALUATION OF EARLY CHILDHOOD INTERVENTION

Takanishi (1979) points out that the evaluation of early childhood programs is based upon certain assumptions concerning the nature of developmental change and how it occurs (Overton & Reese, 1973; Reese & Overton, 1970). These assumptions include conceptualizations of change as behavioural versus structural, or continuous versus discontinuous. Further assumptions concern the cause of change: unidirectional versus reciprocal causality, or linear causality versus organized complexity. In order to illustrate the implications for evaluation of these different conceptualizations, Takanishi cites the work of Sigel (1972) who described change resulting from pre-school intervention programs as organized complexity.

> The child is composed of a variety of sub-systems (perceptual, cognitive, emotional, etc.) whose relationships to each other vary over time. Change in one sub-system is related to changes in others. Sigel noted that even though development is, overall, a cumulative process 'the cumulative effect may express itself in various effects at different times'. (p. 151).

Takanishi points out that -

> Evaluation of early childhood programs, almost without exception, exhibits a unidirectional bias in which the program is viewed as the 'treatment' which causes some change in the child. This unidirectional bias is often reflected in discussions of the 'predictive validity of a program'. (pp. 151-152).

Recognition of the multiple, interacting and conflicting influences on behaviour which is integral to the transactional developmental perspective means that there is less concern with prediction of later behaviour. The dynamic interrelations among physical, affective, social and cognitive development, (Shipman, 1978) the individuality and plasticity of growth patterns (Jones, Bayley, Macfarlane & Howzik, 1971), and the conceptualization of change as reflecting periods of instability of individual differences and/or discontinuities in developmental function across age (McCall, Eichorn & Hogarty, 1977), illustrate the complexities involved in evaluating the effects of pre-school intervention programs. Takanishi claims that a developmental perspective accepts the serious limitations in proving the "effectiveness" of these programs -

> ... this perspective rejects an efficient cause approach to studying program impact... Most of the evaluation studies are correlational and causality cannot be inferred. Even in those projects which are experimental and under more strict control and monitoring...other limitations are present. There are multiple pathways to any observed outcome. Just because we are able to demonstrate that a program was effective in terms of certain outcomes, we cannot prove that the results were due to the program per se. Also positive results based on one program cannot be generalized to other programs in other communities (Cronbach, 1975). (Takanishi, 1979, p. 183).

The transactional model of child development assumes that the purpose of evaluation of early childhood programs is directed towards... "involving the participants, including the evaluators, in understanding program development, adult (staff and parent) development, and child development". (p. 155).

Evaluation should stimulate critical reflection concerning what is taking place (Carini, 1975; Eisner, 1977; Cronbach, 1975; Partlet & Hamilton, 1976) and provide feedback about the program to the staff and other interested groups in terms that are comprehensible and that lead to more sound practices (Stake, 1978). Takanishi concludes that - "the most important criterion against which an evaluation is judged is its utility, or the extent to which the evaluation results in program improvement and child development." (p. 156).

CONCLUSION

Developmental and intervention programs for at-risk and handicapped children and infants are time consuming, labour intensive and costly (Tjossem, 1976). It is clear, from the foregoing review, that the evidence concerning both the short and long-term effectiveness of these programs is equivocal and inconsistent and that there are many unresolved methodological and interpretive dilemmas demanding further investigation. The need for these programs, however, is not in question. The rights of handicapped children to special care and attention, recognized by the United Nations General Assembly, should ensure both the provision of appropriate programs and continuing attempts to monitor their effectiveness.

CHAPTER 3

RESEARCH METHODOLOGY OF THE STUDY

The purpose of this study of early intervention programs in Australia was to survey current programs to determine their primary characteristics, to sample the opinions of parents of children involved in early intervention programs and, partly through drawing on the experience of people offering early intervention programs, to identify the important issues related to the further development of early intervention.

3.1
DEFINITIONS

Three issues needed to be addressed: definitions of early intervention and of handicap, the identification of relevant programs, and the collection of data.

In seeking to delimit the field of intervention programs we found that definition at several levels was required. It was not enough to define early intervention programs very broadly, although that was important for identifying as many programs as possible. In order to provide common descriptive data on programs, definitions of early intervention had to be used specifically for that purpose. Some programs of early intervention that certainly reflect the concept do not actually serve children directly. For example, the Family Training Unit of the Intellectually Retarded Services in South Australia provides training to parents that could be legitimately defined as early intervention and, in fact, was considered by some attendees at the South Australian Workshop to be "one of the best early intervention programs we have". However, it was not possible to include the Family Training Unit in a data pool in which the number of children in programs is compared on the basis of disability, age, sex, etc., because no children are directly served by the program. Several departments of education in the various states use an itinerant teacher service to support preschool teachers with handicapped children placed in regular classrooms. That kind of service, broadly categorized as early intervention, is not comparable with a service which provides direct and continuing personal contact between the professional and the child. In this report, early intervention programs are discussed as broadly defined, EXCEPT in the section dealing with the questionnaires completed by or on behalf of programs. In that section a somewhat narrower definition has been used to describe programs that share certain comparable characteristics.

3.1.1
Definition of Early Intervention Used for Identification of Programs

For the general consideration of early intervention in Australia, and in the process of identifying existing programs, early intervention programs were defined as *planned and organized efforts to enhance the development of children under school age who are at risk of developmental delay due to intellectual, physical, sensory, multiple, or other disabilities such as autism.* No attempt was made to exclude programs on the basis of philosophical orientation, intensiveness, degree of structure and formality, base of the program (in the home or outside it), sponsorship of the program, (whether by a medical or educational institution or by a government or non-government agency), emphasis on research or service, or degree of involvement of parents in the program. This broad definition was intended (a) to prevent the possibility of omitting some appropriate programs where program staff used a very specific and limited definition of early intervention, and (b) to give the research team knowledge of interrelated services broadly defined as early intervention and relevant to early intervention in a narrower sense.

A variety of activities can be broadly defined as early intervention or related to intervention. Assessment is the process of determining what special problems or needs a child may have. Assessment ideally results in referral to a program of treatment, habilitation, remediation or education. Examples of assessment might be a guidance officer's testing of a child in an educational setting or diagnosis in a medical setting.

Care is attendance to the needs of a child for food, shelter, protection, and companionship. Examples are a foster care program and institutionalization of a child when parents are unable to meet these needs.

Treatment, or intervention, generally anticipated to be of relatively short duration, is based on the assumption that, when change is effected, the child will continue to develop without further intervention. In fact, the goal of treatment is to eliminate the necessity of continued therapy. An example is tendon surgery for a cerebral palsied child.

3.1.2
Definition of Programs for Questionnaire Purposes

Most programs defined by their staff as early intervention included activities falling into the categories of habilitation, remediation, and education, but use of these terms and others is dependent on whether the setting for a particular program is medical, educational, social welfare, or recreational. Most programs appeared to fall into the categories of remediation and education although some habilitation programs have been included.

Habilitation appears to be usually recognized as a kind of intervention that focuses on learning of a circumscribed nature, primarily the development of self-care skills. An example might be a feeding or toileting program.

Remediation is often perceived to be a kind of intervention that, assuming circumstances that put a child at risk of developmental delay, seeks to remedy the situation by teaching the child, by various means, to perform a variety of tasks that will foster growth in the area of expected delay. Remediation seeks change in either physical or mental development and is distinguished from habilitation by its wider scope. It assumes that, once the situation is remedied, development can continue in the mainstream or closer to it than otherwise.

Education is usually seen as a kind of intervention that assumes developmental delay in broad skill areas that are especially relevant to future education: cognitive development and language primarily, but in many cases motor skill areas also. It is assumed that education is a continuing process and that growth does not end after a new skill is learned but rather that each new skill forms a basis for further growth.

We determined that, in order to be eligible for inclusion in this part of the study, an *early intervention program* needed to satisfy the following criteria:

1. It provides a direct and continuing service to children by professionals or paraprofessionals such as therapists, teachers, psychologists, social workers, medical personnel, "social trainers", or "activity advisers".
2. It is designed specifically for young handicapped children in any of the following disability areas: intellectual handicap, physical handicap, hearing impairment, visual impairment, multiple handicap, autism or unspecified developmental delay.
3. It is specifically designed to change the child's skills and behaviours in order to encourage development as close as possible to the norm and to prevent problems that may be caused by the disability.
4. It can be defined as habilitation, remediation or education rather than as assessment, care or treatment.
5. It is dependent on more than one person for continuity. In other words, there is a sponsoring association or a source of external funding that suggests support other than by a single practitioner offering the service.
6. It was operating in 1979 or 1980. Projects that were known to be no longer operational in 1980, when the data analysis was undertaken, were eliminated.

Certain kinds of programs for young handicapped children were excluded from the questionnaire study:

- those based on a medical model that could more properly be classified as prevention, diagnosis, treatment or care;
- those based on an educational model that could more properly be classified as assessment for the purpose of planning future placement;
- those based on a social welfare model that served the handicapped child through care alone or indirectly through referral to other services;
- those based on a recreational model that were perceived as entertainment only: for example, attempts to teach a specific skill such as swimming or horseback riding, or short term activities such as camps.

Some programs defined as early intervention and described in an overview of state programs may not be included in the questionnaire study, either because the research team learned of their existence too late for their inclusion or because the program staff did not respond to enquiries or requests for a completed questionnaire.* In a few instances programs provided no data because their records did not permit convenient retrieval of requested facts.

There were two other grounds for excluding programs. We assumed that an early intervention program ought to have some type of professional input. Thus playgroups organized and operated by persons without professional training (such as the parents of participant children) were excluded. Because the continuity of services of private therapists, nurses, doctors, or consultants is dependent on one person rather than a group, community, institution, or department, it was assumed that private practitioners were not an appropriate subject of study although their participation in the early intervention process, particularly in identification of a need, may be crucial.

One aspect involved in the definition of early intervention programs is the age of the children for whom the early intervention program is intended. What is early? Purists might contend that, unless a program is designed to provide intervention for children as soon as developmental delay is suspected, it does not constitute early intervention. According to this view programs with a lower age limit - for example, a kindergarten not accepting children under the age of three - are not providing early intervention but,rather, are offering service of some other kind. In our study, however, programs with a lower age limit of two, three, or four years were not excluded on that basis alone. Further, while we focussed on programs for children at younger age levels, programs for older under-school-age children were included if they exhibited a very special effort to accelerate the handicapped child's development.

In general, pre-school and kindergarten services are based more on the notion of preparation for school and/or later development than on the idea of optimal development from the time of recognition that certain obstacles to "normal" development may exist. Especially when handicapped children are incorporated in pre-schools with a minimum of support or additional help, the notion of early intervention is strained. To exclude, as we have done, pre-schools with itinerant or visiting teacher programs does not suggest that they are unimportant but rather that they are difficult to describe as early intervention programs except in a broad sense. Again, the Australian Preschool Association is not treated as an early intervention program in the study, yet many of its activities, such as the publication of "Parent News Sheets" providing guidance for parents on children's development, are a valuable contribution to early intervention.

The term "intervention" has widely applicable denotations; it can mean any kind of act to change or interfere with a predictable or expected occurrence. Any attempt to change the environment or personal characteristics of an individual could, then, be described as intervention. Thus, effecting social, economic, political, medical and other changes can facilitate the optimal development of a child who otherwise might have been born with a defect or deprived in physical or psychological ways that would have had detrimental and handicapping effects. Viewed in this light, a politician sponsoring a Bill to increase children's allowances for very low-income families could be said to be involved in early intervention. The scope of this concept of early intervention exceeds the boundaries of our study, although such a concept reflects the complexity and interrelatedness of the needs for assistance of handicapped children and their families.

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* It is possible that in some cases the addresses we knew were outdated so that our enquiries did not reach the program or that we directed our enquiries to a person no longer working in the program.

Another source of confusion arises at times from the official nomenclature used. For example, some programs that might otherwise be called "early intervention" are classified by their sponsors as "ongoing assessment". An education department that does not provide education for under-school-age children may incidentally provide early intervention as part of the process of determining appropriate later placement in a pre-school or primary school. An example of such an assessment program is a playgroup provided by the Metropolitan West Regional Office of the New South Wales Department of Education. With parents accompanying them to learn how better to teach their children, the children are being assessed, but they are necessarily also involved in the process of learning language and social skills. This program was not included in our surveyed programs because it is understood as providing assessment only; yet it clearly engages in a type of early intervention.

In the Barwon Regional Child Health Centre of the Victorian Health Department, "ongoing assessment" is provided through a play assessment program that may not only provide the opportunity for observation and assessment but also affect the development of the child over a period of time. Yet the program is defined as an assessment program and, though examined during a site visit as an example of the Early Childhood Development Programs in Victoria, it was excluded from our survey data.

3.1.3
Definition of Handicap

The definition of *handicapped child* also presents some difficulties because to an extent the distinction between handicapped and non-handicapped is artificial. Children included in the definition of those served by early intervention programs for handicapped children were those at risk of developmental delay due to intellectual, physical, sensory, or multiple handicaps and also such disabilities as autism. We did not specifically look for programs dealing with problems such as asthma, heart conditions, kidney dysfunction, amputations, and cancer. Nor did we search for programs initiated to help those suffering from social or emotional deprivation, or behaviour problems, although we recognized that these can also be sources of developmental delay. Since "learning disabilities" are usually identified in a school setting, not during the pre-school years of a child's life, we did not seek to identify programs for children with specific learning disabilities. If such children were catered for in other programs for handicapped children that were the major focus of our attention in this study, they were, of course, not excluded.

3.1.4
Definition of Program

Finally, the definition of a *'program'* has also caused difficulties. We needed to determine whether an umbrella program with regional centres should be considered a single program, or whether each regional centre should be seen as providing a separate program. We may not have been entirely consistent in dealing with this but we have tried to capture the perceptions of program personnel. In some cases department or agency officials preferred talking with us from the standpoint of the umbrella program but we might have been able to visit and see in operation only one of the regional centres among which there may or may not have been considerable variation. We have not satisfactorily resolved this problem, and programs as individual cases and as clusters have been included in our listings.

3.2
IDENTIFICATION OF PROGRAMS

The Office of Child Care of the Department of Social Security provided lists of funded programs that formed the basis for initial program enquiries. In expanding this initial list of early intervention programs, we made enquiries of:

(a) government departments of health, education, and welfare, a majority of which replied, providing information on government and non-government programs;

(b) tertiary institutions with departments of special education, child development, speech therapy, physiotherapy, or occupational therapy;

(c) hospitals listed in the medical directory as having children's services;

(d) voluntary associations serving the handicapped;

(e) known programs which could suggest other directions for enquiry as well as providing information about themselves; and

(f) persons attending the workshops held in all capital cities.

3.3
DATA COLLECTION

Data on the programs were collected through site visits and through questionnaires.

3.3.1
Site Visits

Several site visits in each state were planned to provide the research team with a series of observations to develop a framework for consideration of issues and an understanding of early intervention programs throughout

Australia. The research team made full site visits in which virtually all of the required information could be collected, and partial site visits which, while too brief to permit extensive data collection, nevertheless provided useful information and insights. In all visits program staff provided information and, in most, at least one aspect of the program was observed in operation. In addition, during visits to each locale, telephone calls were made to staff of various programs which could not be visited, and departmental administrators were interviewed so that we might obtain a picture of the overall pattern of early intervention. Most of the site visits took place between August and December of 1979, but two took place earlier, during development of the site observation plan and a few were conducted in June and July of 1980 in conjunction with workshops related to the study.

The overall plan included at least five sites in large states and at least two in small states; this minimum number was increased, where possible, often when staff were planning to be in the area for other reasons and could incorporate a visit. *

Most of the sites were located in or near capital cities. However, a small number of country visits was undertaken; these included programs in Launceston, Tasmania; Whyalla, South Australia; Toowoomba, Queensland; and Newcastle, New South Wales.

Sites were selected in order to achieve representation of government services (health, education, and welfare departments), voluntary associations, and other types such as those based in tertiary institutions and/or having a research orientation. Also included were services about which there was initial uncertainty concerning the provision of early intervention per se, and knowledge gained about these services permitted refinement of the definition of early intervention and understanding of various concepts of intervention; in addition, the information facilitated the determination of the programs to be included in the questionnaire study.

Selection was also designed to achieve representation of services offered to children with various handicapping conditions. It should be noted that, although official policy often permitted services to children with any one of diverse handicaps, the pattern of referral and the distribution of other services often meant that the vast majority of children served by a program "open" to diverse disabilities shared one major handicapping condition.

Selection was made on a national, not a state,basis. A balance of various types of programs could only be achieved nationally because too few programs in each state could be visited to obtain a reasonable sample of programs for each variable.

The following is a summary of the types of sites visited as defined by disability catered for, in official or unofficial policy governing eligibility. However, in those catering for diverse disabilities, the majority of clients were intellectually handicapped:

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* The number of sites visited in South Australia and in New South Wales was higher than for the other states for this reason.

Diverse disabilities (any or almost any handicap)	20
Intellectual handicap	7
Physical handicap	5
Hearing impairment	4
Visual impairment	3
Multiple handicap	3
Autism	2
Total:	44

Appendix A lists the site-visited programs by state and provides limited information about them, their affiliation and the primary disability of children served.

The kinds of information collected on site visits included:

Background:	purpose and base of program, history, geographical area served, objectives, policies on functioning, eligibility, staff duties, ancillary services, policies regarding clients' use of other services and co-ordination with other services.
Environment:	the network of services, funding, outside consultants, volunteers, training for volunteers, community support, student trainees, external research involvement.
Clients:	children served - sex, age, disability, hours per week served, hours per session, sessions per week; numbers of non-handicapped children; characteristics of parents and families: size of family, ethnicity, distance from centre, centre contact with parents, involvement of parents in the program, parents' organization, parent meetings or workshops, parent influence on programs.
Structure:	physical facilities (outdoors and indoors), equipment; general locale, transportation, community resources; organization and administration; regular staff (job description, roles, qualifications, in-service training, full or part-time experience); methods of communication - with general public, potential clients, related services, parents, staff.
Process:	procedures for accepting new clients; assessment; sources of referral; program components - "curriculum", focus of program or range of developmental areas covered, theoretical or philosophical orientation, materials used, timetable, determination of the program for each child; ongoing evaluation; supplementary services; details on home visits, if applicable; unique characteristics of program; grouping of children; allocation and use of staff and equipment, staff consensus and techniques; views of the value and purpose of play; use of toys, evaluation of the program, methods of record-keeping, internal research.

General: strengths and weaknesses, main needs for continuation and further development, areas of concern.

3.3.2
Questionnaire Study

Because of the need to limit the number of site visits, information from programs which could not be visited was collected via questionnaire. Staff of site-visited programs appropriate for inclusion in this wider study also completed questionnaires or checked for accuracy questionnaires completed for them by the research team. These data formed a common pool of information for the description and analysis of national programs presented in Chapter 4.

The questionnaire was developed to collect the most important information as judged from site observation experiences, subject to the restrictions imposed by using a questionnaire format. It elicited information on the year when the program's services began and the forces that influenced its establishment; the number, ages, and primary disabilities of the children served; changes in the program since its inception; funding sources; administrative structure; base (centre, home); parent participation and communication with staff; facilities; type of staff, staff training opportunities; publicity; assessment methods; materials used; the purpose of the program; self-evaluation methods; problems or needs, strengths, and expectations of the future. (See Appendix B for a copy of the questionnaire).

Open-ended questions as well as questions with pre-formulated options were posed, and analysis thus involved consideration by the research team of a wide range of answers, many of which were unique to a particular program.

3.3.3
Questionnaires Directed to Parents

We considered it essential to gather information on parental assessments of the programs attended by their handicapped children. During site visits it was possible for the researchers to converse with a small number of parents, but the views of a much greater number of parents were systematically obtained and analyzed on the basis of questionnaire responses. Early intervention programs associated with the following* co-operated to forward questionnaires to parents of children served by them:

New South Wales: Macquarie University Down's Syndrome Program
Marsden Hospital (now "Laurel House")
Newcastle College of Advanced Education Baby Program and Pre-school Program
Shepherd Centre
Sub-normal Children's Welfare Association Playgroups:
  Leichhardt
  Turramurra

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* 3-5 in each program mentioned.

Victoria:	EPIC, Preston Institute of Technology Royal Victorian Institute for the Blind Shannon Park Spastic Centre
Queensland:	Central Assessment Clinic Education Department Early Intervention Programs: Acacia Ridge Aspley Mt. Gravatt Queensland Sub-normal Children's Welfare Association
South Australia:	Intellectually Retarded Services Kate Cocks' Memorial Family Services Regency Park Centre Whyalla Early Childhood Resource Centre Woodville Spastic Centre Nursery and Kindergarten Program
Western Australia:	Child Study Centre, University of Western Australia Division for the Intellectually Handicapped Speech and Hearing Centre
Australian Capital Territory:	A.C.T. Therapy Centre Hartley Street Centre Malkara Special School

Although parent questionnaires were not used in Tasmania and the Northern Territory, their views were solicited at workshops in Hobart and Darwin.

The parent questionnaire asked for such information as the age, sex, and disability of the child, the number of children living at home, aspects of the early intervention program, reasons for participating, assessment of the usefulness of the program, suggestions for improvement, the relationship between program staff and family, expectations of the future, sources of help and encouragement, other programs serving the child, and the parents' needs and worries. (A copy of the questionnaire is found in Appendix C). To make the task of questionnaire completion minimally time-consuming, pre-formulated options were provided in many cases, but several questions permitted free responses including a final question asking for any information or opinion that the parent wished to provide. These free responses were extremely valuable, not only because the data were found nowhere else, but also because they communicated the essence of parental feelings. A sample of these comments, with all signs of personal identity removed, are found in Appendix D.

3.3.4
Workshops

From the outset the research was conceptualized as an interactive process in which program staff and parents would influence the design and interpretation of the research. Workshops for staff and for parents held in each capital city in the winter of 1980 served two major purposes: they permitted the research staff to communicate initial findings and identify important issues and allowed program staff and parents to correct misinterpretations, communicate their perspectives on the issues we had identified and, additionally, to identify further issues. This was an essential step in the research. Not only were the workshops useful in advancing the research but also they fostered communication between programs. They generally entailed a report on the purpose, methods, and findings of the survey aspects of the study, discussion of significant issues by panelists on the program workshop day and by attending parents on the parent day, followed by open discussions based on previous activities or attendee initiated concerns. (See Appendix E for a review of workshop activities and evaluations of the workshops.)

3.3.5
Other Methods and Procedures

A variety of materials used in early intervention programs was studied (see Appendix F), as were literature on evaluation methods and reports of research on early intervention programs.

Two pilot studies of young handicapped children were also carried out. A longitudinal study of the characteristics of mother-infant play was made with a Down syndrome infant who was developmentally delayed. Observations were made of the child from 5 months of age to 15 months in interaction with his mother. A second study involved eight children each of whom attended both a special pre-school for handicapped children and also a regular kindergarten or pre-school. Play behaviours were observed in each setting. Videotapes were recorded in both laboratory and program settings and were analyzed for the purpose of learning what could be indicative of the play needs of young handicapped children for early intervention programs carried out by parents and professional personnel. (See Chapter 7).

Related to the early intervention study and part of the overall project was a study of toy libraries. This study was carried out by extensive questioning of staff of toy libraries for the handicapped as well as a literature review to set an international context for the Australian scene. A report was written*, a summary of which appears in Chapter 8, because toy libraries are an important resource for early intervention, particularly as carried out by parents of children who have not been "aligned" with any service agency for handicapped children.

Although survey methods were central to the study, a program operated by the New South Wales Department of Youth and Community Services was studied intensively to obtain an understanding of the issue of co-ordination of services to young handicapped children. Two researchers each spent one week accompanying a staff member of the program during daily activities. A log was kept by each researcher, and because the activities of the personnel involved interaction with parents and other agencies serving handicapped children, impressions of needs and problems at the community level could be gained. In addition, the reactions of other related agencies to the work of the particular program under study were obtained by questionnaire, and insights into the operational aspects of the program were gained by interviews with administrative personnel, by questionnaires answered by those involved in providing services, and by questionnaires from parents who received those services. Although the present report does not specifically focus on this single program, its study in this intensive manner gave the researchers an opportunity to see one program in greater depth than was possible with questionnaire or site-visit methods.

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* Elkins, J., Calder, J., Conrad, L., Shepherd, J., Coulston, A. & Willis, M., 1980. *Toy Libraries in Australia:* A report with special attention to their role in services for young handicapped children and their families.

The Program Analysis of Service Systems (Wolfensberger, 1972) was applied experimentally in the early intervention program setting since it is based upon the important principle of normalization. Thus PASS scores were generated for several programs visited early in the study. However, PASS was not ideal for the present study of early intervention programs.

An example of a brief narrative highlighting negative and positive aspects of a single program according to PASS principles is set out in Appendix G. Investigation of the PASS system of evaluation suggested that an understanding of the normalization principles through training in the PASS procedures might be a valuable exercise for program staff involved in self-evaluation, but direct application of the scoring system was not thought to be appropriate for program evaluation.

3.4
LIMITATIONS OF THE STUDY

Because the study is not an outcome evaluation, it cannot provide answers to questions such as the relative effectiveness of different approaches in facilitating learning achievements.

Many program staff are concerned about several important questions. What is the optimal time that children should spend in a centre-based early intervention program? How much time should be spent in various kinds of activities? Is a home-based program more or less effective than a centre-based program? Does parental involvement make a significant difference in children's performance? How many children should be included in a group program? Only indirect evidence which might help provide answers could be provided by the present study, moreover, it must be emphasised that there cannot be simplistic answers to complex questions such as these, where the characteristics of individual children and their families, and the environments of the programs, must shape the directions.

Questionnaire data were provided by program directors or other staff members. Sometimes quantitative data were unavailable, and estimates were made. Thus, the questionnaire responses may to some degree by idiosyncratic, reflecting the perspectives of the individuals who completed them. The study did not extend into the follow-up of children and parents some years after early intervention, and thus cannot provide evidence on the long-term effects of these intervention programs. Another aspect that lies beyond the bounds of this study is the cost-effectiveness of early intervention. Finally, the study was not intended to rank-order early intervention programs but rather to explore the meaning of early intervention and to identify issues and areas of concern that ought to be considered as early intervention programs and related services in Australia contemplate change in response to need.

CHAPTER 4

OVERVIEWS OF EARLY INTERVENTION IN THE STATES AND TERRITORIES OF AUSTRALIA

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The patterns of early intervention in each state vary considerably. These variations reflect underlying differences in the evolution of services for the handicapped, as well as specific differences in the development of early intervention from state to state and territory to territory. The following discussion of early intervention in each state and territory provides a context for data on the nation's early intervention programs in two ways: firstly, by providing an overview of the major features of early intervention at the time of the research team's contact with programs; and secondly, by illustrati[illegible] the general features of the development of early intervention programs [illegible]rvices in each state and territory with reference to a small selec[illegible] programs reflecting aspects of the pattern of service delivery i[illegible]cular state or territory.

Each summary overview of a state or territory has been organized in a way that attempts to reflect the particular pattern of evolution of early intervention programs in that state or territory. The summaries are ordered according to the population size of each state and territory. A list of programs identified by the research team as offering early intervention services** follows each state or territory overview. The programs are categorized in the lists according to administrative relationship to government or voluntary groups. However, it should be noted that programs may be substantially or totally funded by a source other than the administrative agency and that, in some cases, the interrelationships are too complex to be reflected accurately in a list or general discussion.*

Specific mention of particular programs and their characteristics should not be interpreted as suggesting that these programs are better or more notable than others but only that more information had been obtained about them or that, as examples, they convey the ideas to be illustrated. Despite our attempts to obtain an inventory of programs and to update the listings of programs progressively, some programs have inevitably been omitted. For those discussed, it is recognized that the changing nature of early intervention programs will have also inevitably led to unreported changes in the details of the operation of some programs.

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* *Although the Northern Territory precedes the Australian Capital Territory, as is the convention, the population of the Australian Capital Territory now exceeds that of the Northern Territory.*

** *Appendix H is an alphabetical list of programs by state which provides addresses.*

4.1
EARLY INTERVENTION IN NEW SOUTH WALES

In New South Wales, in 1979/1980, children under five with disabilities other than hearing impairments had no official government service provided for continuous developmental intervention. Attempts had been made to fill this gap by government agencies, such as the Health Commission, the Education Department and the Department of Youth and Community Services, and also by voluntary groups.

Health Commission assessment services had in some cases led to provision of early intervention as a follow-up, an extension of the concept of treatment. The Education Department had become involved, by taking over services previously sponsored by voluntary associations; by establishing preschools; and sometimes by providing a kind of intervention that is officially considered part of the assessment of children, constructed to guide a decision about future schooling. The Department of Youth and Community Services had played an important role in encouraging community groups to establish services that could be funded by government to meet urgent needs. This department had responsibility for payment of grants or subsidies to voluntary organizations and for the licensing and the supervision of voluntary associations, preschool facilities, and residential facilities. In these ways, the department had an influence over the kind of service offered to children under five. Its field services were, however, limited to 'advisory services and supportive supervision'.

In fact, all three departments had broad powers that gave them avenues of service to young children with disabilities, but none had specific responsibility for an early intervention service. Historically the Health Commission had the closest links with early intervention services for young handicapped children. Many Health professionals still perceived educators and others as entering an area in which Health program staff are most competent to operate. On the other hand, many educators felt that Health staff had a tendency to view infrequently occurring treatment as an episodic intervention, offered by staff who lacked knowledge of early childhood development and education of children with special needs. Further, some educators viewed hospitals and clinics as non-normalizing environments for early intervention, reinforcing the mistaken notion that handicap is an illness or disease. To these educators diagnosis and treatment were seen as the legitimate domain of the Health Commission, whereas education, no matter how young the child, should be the responsibility of trained educators.

The Handicapped Persons' Bureau has had the task of attempting to coordinate the activities of these two departments, and those of voluntary groups and community organizations, both specialized and generic, in order to facilitate the optimal provision of services to children with disabilities and to their families in what are considered the crucial preschool years. The task of co-ordination was hindered to some extent by the fact that the regional divisions of the three departments were not identical; at times this mitigated against effective co-operation.

Despite these difficulties, co-operation does occur. For example, the Southern Tablelands Child Development Unit, centered at Goulburn, was a nonmetropolitan program that had involved the co-operation of all three major government service providers. A meeting between regional health and education directors led to establishment of the Unit, and at the time of completion of our questionnaire the Education Department employed two persons full time, the Health Commission six workers part time, while two full time personnel were hired with funds from the Department of Youth and Community Services. However, only one full time and 5-6 part time staff worked on early intervention aspects of the program; the speech therapist and physiotherapist provided only three hours a week each, and two nurses 15 hours per week, on an average, to serve thirty-six children under 5 and twenty more under 6. The service is an illustration that co-ordination is possible.

An inter-departmental Standing Committee on the Handicapped had been established for New South Wales, comprising the Director of the Department of Youth and Community Services, the Director-General of the Department of Education, the Deputy Under-Secretary of the Treasury and the Commissioner for Personal Health Services of the Health Commission of New South Wales. One of its major functions was the co-ordination and integration of departmental and voluntary services for the handicapped, including physically, intellectually, and emotionally disabled persons.

Regional committees on the handicapped had been set up by the Standing Committee on the Handicapped and each was to include the Area Director of Education, the Regional Director of the Health Commission, and the Senior District Officer or Resident District Officer of the Department of Youth and Community Services. The regional committees used the boundaries of the Education Department's area directorates. Up to the time that information was available to the research team, the chairman of each regional committee was the Area Director of Education, though this was not a requirement of the Standing Committee. The regional committees in each of the eleven regions had responsibility for identification of handicapped children in that area, compilation of a statewide index of intellectually handicapped persons, survey and inspection of facilities, performance of needs assessments, and advice to voluntary organizations. One of the problems faced by the Standing Committee in relation to early intervention, however, was that its stated administrative tasks did not include, among programs for development of community services for the intellectually handicapped, any specific mention of early intervention.

The arguments concerning approaches to intervention advanced by professionals working in health and education often seemed to take insufficient account of the changing nature of approaches to early intervention in both fields. These changes are gradual, however, and as in other states, characteristics of previous methods of service delivery may be seen in the updated services. For example, the Health Commission has had Grosvenor Hospital as a central assessment facility for the state. This facility employed domiciliary nurses (Mental Retardation nurses) who extended the services offered beyond assessment to advice to parents, support to the family, and home contacts as a follow-up to assessment. Grosvenor still played a central role but diagnostic clinics were then established in each region, some of which were hospital-based. In the Southern Metropolitan Region the activities of the Health Commission in diagnosis or assessment and support from various regional centres had been subsumed under the general label "early intervention", and implemented by a team at the Bexley Therapy Centre. This centre was part of the Kogarah Mental Retardation Team. Although the team was based at Kogarah, each of the four subareas of the Southern Metropolitan Region had a community nurse and another health professional from the team. The Bexley Therapy Centre operated programs at other locations including Miranda, (in a Baby Health Centre), Randwick, (at a Community Centre), and Peakhurst (at a Community Health and Welfare Centre). A physiotherapist and occupational therapist were full time staff of the Therapy Centre, which provided assessment and early intervention for children experiencing developmental delay, physical and/or intellectual handicaps between the ages of 0-5 years in the Southern Metropolitan Region. The two full time therapists, a part time physiotherapist and occupational therapist, and a pre-school trained counsellor were employed by the Health Commission as part of the team. The Cumberland College of Health Sciences co-operated with the team by providing two third year speech pathology students and two orthoptics students who worked under the supervision of experienced professionals. In 1980 a Parents and Friends Group of the Therapy Centre was given funding from the Department of Social Security to hire a family day care, emergency care and respite care co-ordinator, a special educator and an aide development officer. It is important to note that a means was found to hire the special educator (outside traditional health areas), by using funding from outside the Health Department. The Bexley Therapy Centre, in some ways, resembled the Therapy Centre in the Australian Capital Territory. In Canberra, however, the Education Department provided expertise in early childhood education and special education, whereas in New South Wales, educational personnel were hired by a voluntary parents and friends group that was funded by the Department of Social Security. Clearly this would seem to be unacceptable as a long term solution to the need for expertise from educationalists as well as health personnel.

In the past, the Education Department was responsible for school-aged mentally handicapped children with relatively higher intellectual capacities, and the voluntary associations - the Subnormal Children's Welfare Association, for example, and the Intellectually and Physically Handicapped Children's Association - took responsibility for the schooling of the more severely affected children. More recently, however, the Education Department has been taking responsibility for some of the Subnormal Children's Welfare Association schools and those of other voluntary associations, as part of a policy to provide for the education of all children of school age. Concurrently voluntary associations have been becoming closely involved in providing service to children under five with mental handicaps, regardless of severity. Thus children under school age at the Bambi Nursing Home had a residential program and may also have travelled to Hoxton Park school for a program, both facilities under the auspices of the Intellectually and Physically Handicapped Children's Association of New South Wales. The Subnormal Children's Welfare Association offered regional playgroups and parent support for children under five with mental or other disabilities. Both the Education Department and voluntary associations were actively serving hearing-impaired children under five years of age.

Pre-school Services, an administrative unit of the Departmentof Education, oversaw a number of pre-schools attached to public schools, serving children from 3 years and 9 months of age. Other pre-schools were licensed by Youth and Community Services. The Education Department has responsibility for programs offered by associations previously providing that service, or when it assisted such associations. The Department's two special schools for the hearing impaired were the Farrar School at Croydon Park and North Rocks, which was located in premises of the Royal N.S.W. Institution for Deaf and Blind Children. Programs at these schools began with children at the preschool age of three years. Special nursery classes were held here and at several other centres to assist young deaf children of preschool age and their parents. Another group of special preschools in which the Education Department had an involvement were those operated by the N.S.W. Society for Crippled Children. The voluntary organization provided the buildings and therapists, the Health Department provided salaries of therapists, and the Education Department supplied teachers and part of the funding. The preschool at the main centre(located at the corner of Bedford and Chalmers Streets) was run by the Department of Youth and Community Services with Society staff and Society payment for transport.

The Division of Guidance and Special Education considered that it provided a program of early intervention from the time of diagnosis. Below the age of three a clinic program was carried out to advise the mother on management of the child, to do some limited teaching of the child, primarily for demonstration purposes, and to counsel for future placement. The New South Wales program for young hearing impaired children did not embrace the notion of supporting the mother and child in the home itself. Rather, clinics were set up where the mothers or fathers could bring the children and talk with the teacher of the deaf and the specialist psychologist for the deaf in liaison with audiological and/or medical personnel. Most meetings were with individual parents and the children, but a group program was also available to allow several parents to meet together. The philosophical rationale for the clinic approach was that isolation of the child and mother in the home can cause problems and that support should be provided in a location outside the home. When the child was three, parents made a decision with the help of an educational team concerning placement in a centre-based nursery or preschool program. The setting may have been either a regular or a special one. When the child was 4½, he or she may have entered either a regular class, with support from an itinerant teacher, or a special class. Approximately fifty per cent of hearing impaired children were integrated in regular classes, between 35 per cent and 40 per cent were in special classes associated with regular schools, and the remainder attended special schools.

The Early Infant Stimulation Program of the Handicapped Persons' Bureau, Department of Youth and Community Services of New South Wales was an example of an indirect way of providing intervention: that is, its service was conceived as the facilitation and encouragement of direct intervention by available or potential programs in the community. The underlying philosophy of the program had three major tenets: (1) that young children with handicaps should be assisted in their development as soon as possible after their handicapping condition is identified; (2) that handicapped children's opportunities to participate in 'normal' activities with parents in the home and in the community should be maximized; and (3) that, if institutionalization is necessary, the children should be allowed and encouraged to approximate as closely as possible the life patterns of the mainstream of society. Fourteen co-ordinators, each working in a specific region within a broad area of New South Wales bounded by the Blue Mountains in the west, the Hunter Valley in the north, and Multon-Ulladulla in the south, were responsible for implementing the following operational objectives that focussed on service to handicapped children between birth and the age of 5 or 6:

(1) to undertake, and keep up to date, a comprehensive overview of all relevant aspects of the region being serviced;

(2) to promote community awareness and foster positive community attitudes in matters pertaining to handicapped children;

(3) to engage in, and facilitate, liaison with and between existing community agencies and services;

(4) to encourage and assist in the development of family support services (emphasis being on self-help);

(5) to encourage and assist in the development of child support services (emphasis being on self-help);

(6) to act as a catalyst in promoting community involvement on behalf of the handicapped child. *

Although the Early Infant Stimulation Program did not itself provide a direct early intervention service but an environment in which such services could be optimally developed and used, an understanding of its role was of major importance in our achieving an adequate grasp of the New South Wales scene.

Not only government services but a variety of voluntary associations and private organizations provided early intervention. Several programs in New South Wales were associated with tertiary institutions as well. One of the advantages of the voluntary association is its ability to draw on a number of government agencies, state and federal, for funding and thus to hire teams that incorporate widely varying disciplinary backgrounds. They also have, however, the disadvantage of lacking the many specialized and generic centres that could be adapted to localized services.

Like other early intervention programs for the blind, the Enfield Child Development Unit program has been greatly influenced by the work of Selma Fraiberg (1971), who observed the problems that a visual impairment created as children learned to interact with the people and things in their environment, as they developed adaptive hand behaviour, and as they developed gross motor skills. The purpose of the intervention program of the Royal Blind Society was to find 'adaptive substitutions for vision' so that the child could 'achieve a coherent sensori-motor organization'; the intervention needed to take place in the home in order to take advantage of that naturalistic setting as soon as an impairment was identified.** The influence of Wolfenberger's (1972) notion of normalization was also acknowledged, and one purpose of the home-visiting program developed by the unit was to rationalize admissions to the Royal Blind Society's institution.

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* The six objectives are cited in "Early Infant Stimulation Program for Handicapped Children", December 29, 1978, a document prepared by The Handicapped Persons' Bureau.

** For a discussion of the program see 'The Future of Children's Services', a paper presented by Felicity Purdy to a seminar on forward planning held by the Royal Blind Society of New South Wales on August 9, 1975.

The home-visiting program was carried out chiefly by an occupational therapist who worked with children from birth until two years of age. The objective of the therapist was to help parents to learn how to foster development as close as possible to the normal developmental sequence expected of a child without a visual impairment. Sensori-motor development was emphasized for babies but development of cognitive skills and concepts was also of concern. Playgroups supplemented the work in the home, permitting interaction and social development. For mobile children, an occupational therapist attempted to reinforce development in areas such as communication through auditory, tactile and visual experience, constructive play with manipulative equipment and toys, gross motor skills such as walking, climbing, jumping and balancing, body awareness, and social development. For somewhat older children a kindergarten teacher fostered readiness for integration into regular kindergartens by leading a weekly playgroup in which the children were engaged in kindergarten types of activities. After integration the Royal Blind Society kindergarten teacher then functioned as a visiting teacher to the regular kindergarten on a weekly, fortnightly, or monthly basis. A low vision training program was also provided to encourage the maximum use of available sight. The Royal Blind Society shared one of the advantages of a centralized program: the availability of other support services 'on the spot'; for example, a social worker was closely involved in providing family support, and an orthoptist, consultant physiotherapist, and psychologist also participated.

The Shepherd Centre was the facility supported by the Council for Integrated Deaf Education. It was a teachers' college in which qualified pre-school teachers or candidates for the teacher of the deaf course (Sydney Teachers' College) could train as pre-school teachers of the deaf, and it offered a program with several facets. At the time of a site visit, no child over seven attended the centre. Ten were under three and twenty were between three and five years of age. Thus the entire centre was concerned with deaf children under school age. A home-visiting program was offered for children under three for the purpose of supervising the parent in her home tuition program. A teacher of the deaf visited the home at least once a week, and a home demonstration program was held for country and interstate parents.

At the age of three, some of the children were integrated in an on-site kindergarten. Others were integrated in suburban kindergartens. Each deaf child was also given daily tuition by a teacher of the deaf while being integrated into a normal environment. In addition, evening classes were held twice a month for parents (mothers and fathers), and the mother of each child received instruction at the school her child attended, one morning a week. There was also a correspondence program catering for those who could not visit the Centre often because they lived outside the metropolitan area, and a residential workshop for parents and children were conducted over five days twice a year.

Six full time and one three-quarter time teachers provided services for a total of 34 children enrolled in the programs of the Council. A librarian and a social worker were also hired by the Council. Most of the individual tutorials in school settings were devoted to remedial assistance in school subjects, but speech tutoring using the Ling method was also an important function of the teacher. The oral-aural method was used, in which children are provided with appropriate hearing aids, taught to listen and to lip-read, and given specialized instruction in speech.

The Down's Syndrome Program at Macquarie University is an example of a program offered from a tertiary centre and established to carry out and adapt an overseas program that had appeared successful in that setting. Three groups were provided programs: (1) babies who were given a home-based program, although the mother brought the baby to the centre for training sessions; (2) a toddler or early preschool group whose program was centre-based, although the parent was asked to do some work at home; and (3) an advanced preschool program. Like other programs established primarily for research, it has met a need beyond the original research purpose and could now be more appropriately described as a service involving ongoing research rather than a research project. The research function of the program necessitated a major constraint: children were not to attend any other program, in order that effects could be attributed to a single program.

Although it is best described as a program in an educational setting using educational models, consultants from other than educational backgrounds have been used. (For example, a physiotherapist has been hired part time, although the three full time personnel are teachers.)

In addition to the research aim was the goal of establishing a model program that could be applied in other settings and thus be replicable. The Early Education Clinic in Cremorne, for example, was based on the Macquarie model with some adaptations, as were several programs in other states.

Still a third aim was to develop parent training and to emphasize the role of parents as teachers. The program has changed since its inception, with greater emphasis on integration, parent involvement, and language teaching. Integration was primarily seen to be for social purposes and it was not expected that the kindergarten teacher should provide training.

Macquarie University allowed free use of facilities and clerical help as well as the director's salary, but the program was funded as a registered preschool with a subsidy for part of the teachers' salaries. Parents paid $10.00 per week, with the Department of Youth and Community Services subsidizing in cases of need. The physiotherapist mainly served the infants' program (4 hours per week) and a speech therapist was used in a consultant role. Special education students were also involved, usually as observers. No outside volunteers were involved.

The infants or babies were, at the time of a site visit in September, 1979, between the ages of 5 months and 21 months; the toddler group ranged in age from 23 months to 3 years of age, and the advanced preschool group ranged from 3 years 8 months to 5½ years. Babies received one hour of individual contact per week in home visits. The toddlers received 2 hours on each of 3 days per week in a centre-based group session plus 15 minutes of individual training. The advanced preschool group received slightly more time.

At the same time parent training was provided. Emphasis, however, was placed on avoiding unrealistic demands on parents and siblings, recognizing that a normal family environment should be fostered. The program was highly structured, pre-academic skills were emphasized, and the aim was to prepare children to cope in an integrated kindergarten in which a less structured situation was likely to be found. At the time of our visit a comparative study was being undertaken of the social play in kindergartens and at the centre.

The Allowah Babies Hospital in Dundas is an example of a private residential facility for physically and mentally handicapped children up to 2½ years of age providing an early intervention program in an institutional setting. The Babies Hospital exemplified an awareness that children in institutions at an early age need education as well as care. A second interesting characteristic of the Hospital was that it employed a Special Education teacher to carry out the program, whereas usually paramedical staff were in charge of all activities with the children. The mutual respect of the matron and the teacher, displayed during the brief site visit, show that co-operation between health personnel and educationists can be successful, despite some of the problems generally experienced by other programs in this respect.

The children were divided into three groups. The very young infants tended to be taught from 9-10.15; the oldest group from 10.30-12.00, and the middle group from 1.45-3.00. Each child was assessed using the Macquarie University Down's Syndrome Performance Inventory, and a specific program was designed with precise goals in gross motor, fine motor and language skills. Each child was given a teaching period of about ten minutes per day in which individual attention was paid to the targeted skills, using behaviour modification techniques. On each of the five week days, data were recorded on the child's performance and a skill was judged to have been learned when a score of 4-5 correct responses out of five was recorded on three consecutive days.

While the one-to-one teaching was taking place, other children played in ways that would be likely to generalize their skills, sometimes with a nurse or helper supervising. With older children, story telling, music and organized games supplemented free play. Physiotherapists collaborated with the teacher in the setting of objectives and teaching gross motor skills, and the nursing staff co-operated in teaching language and personal-social skills. With shift changes in the nursing staff, however, a child could have nine different people involved, so that the consistency of intervention approaches was hard to obtain.

A discussion of the Subnormal Children's Welfare Association in New South Wales is instructive for two reasons. First, although originally intended to serve only intellectually handicapped children at lower levels of ability, the Association, like a number of other voluntary groups, was, at the time of the survey, broadening the base of the program and providing for the needs of a variety of disabilities in a number of community settings - a total of 26 when information was last available to us, of which over half were located in the metropolitan area. Over 200 preschool-aged children were served in Sydney alone. Secondly, the Subnormal Children's Welfare Association playgroups exemplified the playgroup approach, used with varying degrees of effectiveness, by many service deliverers in other states.

The playgroups were led by a teacher, occupational therapist, physiotherapist, or mental retardation nurse who met regularly with the other personnel to co-ordinate the program and share skills. The program was provided at least once a week for about two hours, and each program included time for free play, music, physical developmental activities, and fine motor and manipulative instruction. Mothers attended with their children and sat near them in a semi-circle. The music activities were intended to help develop, for example, receptive and expressive language, an awareness of colour, simple numerical concepts, body concept and self-image.

Not mentioned above are other voluntary associations or private organizations offering programs. These included North Rocks Centre for Deaf and Blind and Deaf Children, The Catholic Centre for Hearing Impaired Children, The Illawarra Society for Crippled Children, The Spastic Centre of New South Wales., Laura Hodgkinson Sunshine Home School, Miroma, Rudolph Steiner School, Cooinda, Autistic Children's Association, St. Gabriel's School for the Deaf, and St. Lucy's School for the Blind.

A number of programs broadly defined as early intervention have been discussed in the description of government early intervention services in New South Wales. But there were many other broadly defined programs, developed to a greater or lesser extent. Examples of a service related to early intervention were found in programs essentially offering diagnosis or identification of a special need. Many early intervention programs failed to have very young children because disabilities had not been recognized or, if recognized by parents, had not been diagnosed. An example of an activity of the New South Wales Health Commission that was not early intervention but was related in a significant way, was a screening service, usually carried out in Baby Health Centres. Activities of early intervention programs in effecting change in the social sphere, though not early intervention per se, are important. For example, attempts to reach medical students with information concerning disability are seen by many as essential.

Although many programs were operating in New South Wales, there seemed to be confusion concerning the proper roles of the various government departments and agencies in providing early intervention. Serious conflicts must prevent effective co-ordination of current activities, and a definition of responsibilities that would permit co-operation of professionals in diverse fields to intervene with children and families appears to be essential to improvement of services in the state.

4.1.1
LIST OF EARLY INTERVENTION PROGRAMS (New South Wales)

Government Departments

Health Commission

- Early Portage Intervention Project - Baringa Hospital
- Child Development Program, New England Educational Diagnostic Centre in Armidale
- Bexley Therapy Centre
- Developmental Stimulation Program for Infants - Royal Alexandra Hospital for Children
- Hornsby and Kuring-Gai Area Health Service
- Early Education Clinic, Baby Health Centre, Cremorne
- Handicapped Children's Playgroup, Community Care Centre, Cessnock
- "Laurel House", Marsden Rehabilitation Centre
- Play and Learn Service, Community Health Centre, Taree

- Southern Tablelands Child Development Unit (receives funds from 3 government agencies)
- Grafton Special Needs Playgroup
- Coffs Harbour Special Needs Playgroup

Education Department

- Greenacres School for Special Purposes
- Hearing Impaired Guidance and Special Education
- Tangara School for Special Purposes
- Westhaven Public School

Department of Youth and Community Services

- Early Infant Stimulation Program

Tertiary Educational Institutional Programs

- The Shepherd Centre, University of Sydney
- Early Childhood Clinic, Macquarie University
- Special Education Centre, Newcastle CAE
- Down's Syndrome Program, Macquarie University
- Kuring-gai CAE

Voluntary/Private Parent-Support Group Programs

- Lorna Hodgkinson Sunshine Home School
- Allowah Babies Hospital (private hospital)
- Catholic Centre for Hearing Impaired Children
- Cooinda Playgroup for Special Children (voluntary organization)
- Illawarra Society for Crippled Children
- Miroma Rudolph Steiner School, Vaucluse (voluntary private)
- Playgroups of the Sub-Normal Children's Welfare Association
- Enfield Child Development Unit, Royal Blind Society of New South Wales
- Home Management Program - Autistic Children's Association
- Intellectually and Physically Handicapped Children's Association of New South Wales
- Parent Guidance/Itinerant Teachers of the Deaf Catholic Centre for Hearing Impaired Children
- Spastic Centre of New South Wales
- St. Gabriel's School for the Deaf
- St. Lucy's School for the Blind
- New South Wales Society for Crippled Children
- North Rocks Centre for Deaf, Blind, and Deaf/Blind Children (Royal New South Wales Institute for Deaf and Blind Children)
- Association for Children with Learning Disabilities Pre-school Program, Peakhurst
- Stimulus Early Development Program for Pre-schoolers, Richmond Public School

4.2
EARLY INTERVENTION IN VICTORIA

Victoria had an unusually high proportion of programs supported by voluntary associations, but most of these were subsidized by the Health Commission which played a major role in early intervention. Historically, the Health Authority has had responsibility for all services to infants and under-school-age children, although the Education Department has had a role in the early education of deaf children for many years. Since 1973 the Education Department (by permission and not by mandate) has been permitted to provide educational services to any child on the request of the parent or parent substitute. The need for co-ordination and co-operation between the Health and Education authorities has been recognized, and a Task Force Council of the Special Education Working Party on Early Intervention has been established.

The Health Commission's Mentally Retarded Services seemed to be regarded by its staff as a support group (financial and professional, with a staff of psychologists and social workers) for early intervention programs. Although the Mentally Retarded Services avoided initiation of programs to diminish stigmatization, the staff considered themselves to be acting in a facilitative role, encouraging community groups wishing to initiate early intervention programs as they had encouraged community groups in the past to initiate programs for severely retarded children by establishing Day Training Centres under Mentally Retarded Services. Professional services were available upon request to non-funded as well as funded groups; for example, the Shannon Park Spastic Centre was visited by a Mentally Retarded Services' representative.

The usual course of development of services for severely retarded children in the past was for community groups to form, seek funding from Mentally Retarded Services and establish Day Training Centres to serve the severely mentally retarded at any stage from birth to death. About 60 of these developed, some of which now operate under the authority of the Education Department.

There were two ways an early intervention program could in 1980 be funded by Mental Retardation Services:

(1) If a community committee established a group of 12 children with special early intervention needs, this group could be directly funded as a Day Training Centre by Mentally Retarded Services. Funding covered salaries for teachers as well as capital expenditure. (Example: Kalparrin)

(2) If an early intervention program was initiated in a Day Training Centre already established and receiving Mentally Retarded Services funding, the funding for the early intervention program was available through Mentally Retarded Services as part of the total support of the Day Training Centres. (Example: Sunshine Group)

Thus Mental Retardation Services subsidized early intervention programs and offered professional consultants but did not offer early intervention programs. Thus it could be described as engaging in a broadly defined early intervention activity.

Hospitals also played a role in intervention. The Royal Children's Hospital instituted an intervention unit under the direction of Dr. Court. An Early Intervention In-Service Program was offered for six weeks by St. Nicholas' Hospital, and other hospitals also provided services that might be regarded broadly as early intervention.

Historically, as we have pointed out, all infants and young children have been the responsibility of the Health Commission. A significant development in Victoria has been the Early Childhood Development Programme, a generic program for the entire community that is sponsored by the Health Commission. The program was significant for early intervention for several reasons: it was a program for the entire community and thus a normalizing one; it was regionalized so that service was available in a convenient location; it encouraged the provision of services applying a multidisciplinary concept.

The stated four main objectives of the Early Childhood Development Programme* were:

(1) To foster child development in families with young children largely through personal involvement of the family in an education context.

(2) To provide enrichment programs to enrich the social, emotional and physical environment and to ensure that children with special needs have these needs met optimally.

(3) To provide for the early detection of children who are more vulnerable because of the presence of a condition which may tend to limit optimal development and make the child more open to adverse influence of social or cultural pressures; that is, a health assessment program.

(4) To provide a family support service for families of children with special needs to enable these families to foster and to fulfil themselves in the society in which they live. This family support service is seen as providing a structure for home-centred parent/infant habilitation aimed at keeping the family in the main stream insofar as education and health are concerned.

The kinds of services provided varied widely, and in only a few cases could the programs be seen as belonging within the definition of early intervention programs used in establishing the sample for our questionnaire. In the Barwon Region (Geelong-Colac) part of the Early Childhood

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* Best, John B. & McCloskey, Bertram. Early Childhood Development Programme--Early detection. *Australian Family Physician*, 1978, 7, 837.

Development Programme was a play assessment group which was visited by the research team. This program described itself as assessment and the children served tended to have relatively slight problems, difficult to pinpoint, rather than clearly identifiable handicaps. However, the program activities were typical of playgroup early intervention programs. In the South West Region, pre-school field officer support was offered specifically for handicapped children as part of the overall service for children. Some of these were visited monthly or fortnightly, while some attended weekly activity groups. Siblings of the handicapped also received attention. Further, a Support Group for the Handicapped was established in association with the program. It is necessary to emphasize that this specialized service for children with disabilities emerged from a wider general service for all families with pre-school-aged children; a generic service permits the entire community to benefit while offering assessment and programming for those with problems. Parents in a number of workshops mentioned the need for assistance to children who do not fall into the traditional areas of handicap; the Early Childhood Development Programme was particularly valuable for its usefulness to people who were not easily aligned with longer established services.

The Education Department has had responsibility for some time for service to deaf children. For about 150 hearing-impaired children under the age of 4½ years the Monnington Centre provided services subsidized by the Education Department and conjointly administered by the Counselling Guidance and Clinical Services and the Special Education Branch. Families with a handicapped child might be referred when the child was as young as a few months of age. In addition to serving pre-school deaf children or children with a hearing disability as one of several disabilities, the Monnington Centre extended some services to small groups of pre-school children with other disabilities, such as delayed development, visual impairment, and language disorders. The program was centre-based and involved the input of teachers, social workers, psychologists and therapists for a few hours a week.

As mentioned earlier, the amendment to the Victorian Education Act in 1973 gave the Education Department permission (but not a mandate) to take responsibility for the provision of educational service to any child on the request of the parent. One expression of this amendment was seen in the Education Department's responsibility for those pre-school programs already established in Day Training Centres which chose to come under the authority of the Education Department.

Oakleigh Special Developmental School provided an example of an intervention program supported by the Education Department in a former Day Training Centre. Before it became a Special Developmental School, Oakleigh had a "cradle roll" that enabled parents of young intellectually handicapped children to meet regularly at social gatherings. The Education Department provided, in addition to assessment services, a home-visiting service fortnightly and a fortnightly school-based playgroup for children under two and a centre-based kindergarten program for children from two to five years of age, who attended one or two days a week. A total of about 15 children were served. A meeting was held for parents on alternate weeks and, at these, teachers, a psychologist and a physiotherapist were avialable for discussions.

McCallum House in Ballarat provided an example of (a) a Day Training Centre continuing to operate independently, with Health Commission subsidies and (b) a service outside metropolitan Victoria, offered to country people at a fair distance even from Ballarat. The Early Childhood Programme at McCallum House served between 15 and 20 children, most under three years of age and three under one year of age. One of five pilot programs in Victoria, the McCallum House program for very young children began in 1975 as a playgroup but in 1979 expanded to add a home-based program with weekly visits by a teacher and emphasis on teamwork between teacher and parents. A nursery group emphasized longer and more frequent sessions at McCallum House, and a typical kindergarten program was also offered, with continuing one-to-one experiences between a child and a member of the team. Like other country programs, McCallum House illustrates the need for country services; some parents travelled as far as 212 kilometres for a playgroup session. It also exemplifies the co-ordination of services that can often be very successful, particularly in country areas. For example, the visiting teachers, occupational therapist and physiotherapist on the McCallum House team (the therapists worked with the playgroup) were aided on a consultative basis by a social worker and psychologist who were employed by a local geriatric hospital, a speech therapist employed by a hospital, and a dentist in the service of a state government department.

The Yooralla Society exemplifies a voluntary society, subsidized primarily by the Health Commission, which provided an early intervention service for young children with disabilities. It served nearly 100 children, over 20 of these between the ages of 3 and 6 years and about 20 children under three years. This society (formed in 1977 to amalgamate the operations of the Yooralla Hospital School for Crippled Children and the Victorian Society for Crippled Children and Adults) offered early intervention services for children who were primarily physically disabled, for those whose principal disability was intellectual, and also for multiply handicapped children. For very young children, a visiting teacher service was provided. This latter service was subsidized not by the Health Commission but by the society itself. Each visiting teacher covered about half of the metropolitan area, visiting children under 3½ years about once a week in their homes and also visiting local kindergartens. Playgroup activities supplemented the home visits. The playgroups, following Health Commission guidelines, were small (five children per group) and met once a week for 1½-2 hours. These playgroups were operated from the Yooralla Society pre-school centres at Glenroy, Essendon and South Blackburn.

For children about the age of 3½ years, there were four kindergartens offered at South Blackburn, Doveton, Glenroy and Essendon. The children attended four half-day sessions except at Essendon where there was a group with extended sessions from 9:30 to 2:30. At the kindergarten level, the teachers were paid by the Health Commission; and because the kindergartens were subsidized by the Health Commission, they also had access to Health Commission Pre-School Advisers, who worked closely with Yooralla in the placement of handicapped children in local kindergartens. Also available to the children in kindergartens from 1979 were the services of physiotherapists, speech therapists, and occupational therapists. An interest in research has been shown by the employment of a staff member by the Yooralla Society to plan and co-ordinate research, but no specific study of early intervention had been undertaken at the time of our study.

A multidiagnostic program - that is, a program offered to children regardless of handicap - was operated by the Shannon Park Spastic Centre. It was a community program for the handicapped rather than a service specifically designed to reach children with cerebral palsy. An October 1979 pamphlet entitled "Early Intervention Programme for Developmentally Delayed Children - A Multidisciplinary Approach" provides an excellent description of the program. Children under 5½ years of age who were thought to be developmentally delayed because of a physical or mental disability - even a deprived environment - were eligible for this program which was available for two hours three times a week. The staff consisted of therapists (including a speech therapist or language teacher), a teacher with early childhood experience, a co-ordinator, and consultative staff such as a psychologist, paediatricians and a social worker. Each child during a two-hour session was given individual attention by therapists and afterwards participated in a group session with several other children, their parents, and a teacher. One of the primary purposes of the program was to provide 'integrated therapy'; that is, to provide a transdisciplinary approach. Another important aspect of the program was the emphasis on the integration of the centre program with parent training of the child at home, a home-visiting program supplementing the centre program. The program had clearly defined objectives which included not only fairly specific emphasis on tasks to develop particular skills but also the provision of "free exploratory play" so that the child could initiate activities that enhance learning. The program expressed concern about self-evaluation and provided detailed assessment information on 16 children for analysis. Its carefully kept records exemplify an important component of an early intervention program.

An influential early intervention program in Victoria was the program of the EPIC Children's Centre located at the Preston Institute of Technology. Its influences, in part, resulted from the wide dissemination of the program's activities and objectives.* Children attended the centre twice a week for a total of 5 to 6 hours, but the program was in operation for about 30 hours a week for 42 weeks of the year. Each child received an average of three hours of prescribed instruction per week. Parents were asked to conduct about one hour's work a day for four days a week at home. The six skill categories in which instruction took place were language, cognitive skills, fine perceptual and motor skills, gross motor skills, social skills and self care. The program served equal numbers of boys and girls, with a total of 82 children served. Although some of the children were over three years of age, the majority (53) were younger than this. Almost all of the children were diagnosed as Down's syndrome, although a few had cerebral palsy or a problem that had not been clearly identified. The program might be described as multidisciplinary rather than transdisciplinary: teachers were responsible for the language, cognitive, and fine motor-perceptual motor programs (and also supervised home-based programs in those areas); physiotherapists were responsible for the centre and home-based gross motor programs; the kindergarten assistant and volunteer aides carried out group programs and social development activities at the Centre; a speech therapist worked closely with teacher and parents with respect to language and speech development; the director took responsibility for such tasks as enrolment, publicity, evaluation, in-service training, and parent training. The program was based entirely on applied behaviour analysis, precision teaching, and a direct instruction approach. One of the major concerns of the program was its expansion; originally designed to help about 25 families, it was presently serving over 80, and pressure was necessarily being applied on the staff and resources.

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* For example, the Australian Journal of Mental Retardation, 1976, 4, 23-27 & The Journal of Special Education 1979, 13, 169, 177.

The EPIC program and other tertiary institution programs raise questions concerning their ultimate purposes. Burwood State College and the State College of Victoria have offered early intervention in the past, and many tertiary programs are intended to be short-term, for the purposes of training or research. However, in a community where needs are great the program providers may feel that the program cannot be terminated. Yet tertiary programs are not located in settings where continuity can be assured.

A voluntary association that has had wide local and national influence in regard to early intervention is the Royal Victorian Institute for the Blind; the Victorian Education Department and Health Commission used this program for the training of students and staff in the field. In 1980, the Royal Victorian Institute for the Blind sponsored a very useful three-day national workshop on early intervention for visually-impaired children. Such sharing and disseminating of information are vital for staff, developing co-operation among programs and increased sophistication in application techniques of early intervention throughout the nation. Since a detailed description of this program is provided as an appendix to illustrate the kinds of information sought and provided during site visits, this program will not be described here. (See appendix G).

The toy library movement has been important in relation to early intervention in Victoria. The Noah's Ark Toy Library in Windsor, the first in Australia, and many of its branches, as well as other unaffiliated toy libraries, have evolved as resources for current early intervention services and as primary providers of services in some country areas. In Melbourne, the Noah's Ark at Windsor provided an ancillary service to early intervention, and one of its principal roles seems to have been to supplement early intervention programs. Programs such as those offered at the EPIC Children's Centre and Royal Victorian Institute for the Blind were visited regularly by the Noah's Ark mobile van, and the importance of such a service was affirmed by staff of other programs and by parents. The fact that play is a child's primary activity during the waking hours makes the provision of toys for play a significant means of encouraging play; parents were helped to understand the value of play and to intervene to foster their children's growth.

A privately operated nation-wide program centred in Melbourne - the Australian Centre for Brain Injured Children - has been offered since 1977. It received neither government nor private subsidies and depended upon patient fees as the only financial resource. Its philosophy was not in the mainstream of approaches to early intervention, and the program was carried out by parents and volunteers under the direction of someone trained in the particular treatment program advocated. In fact, its operating theory that handicaps are caused by brain injury and that brain injury can be treated directly by intensive sensory and motor stimulation created controversy that resulted in isolation of the program rather than its co-ordination with other programs. For example, some programs would not accept children whose parents were already committed to the Australian Centre for Brain Injured Children. Like many other early intervention programs, this Centre viewed the parent as central; however, no other program examined in the study entailed the intensive involvement of parents for eight hours a day, six days a week, with a quarterly visit to the Centre for re-evaluation. Although the involvement of volunteers meant a sharing of the parents' responsibility and an opportunity for community effort and education, the sheer physical effort, not to speak of the emotional concerns, of the parent raise questions of the wisdom of the program in the minds of many early intervenors. Two major questions are spotlighted by the Australian Centre's program, and these are significant for most other early intervention programs, although no clear-cut answers are possible. They are: (1) How intensive should a program ideally be? (2) How much can a program legitimately ask parents to do at home? Some parents have, in fact, asked that programs be more intensive with less parent involvement in training. Others feel that too intensive a program robs the child of an infancy that is as "normal" as possible, thus sacrificing total development to development of particular skills.

In summary, Victoria was characterized by the existence of many programs, some of which seem, in the opinions of parents, to be very effective. The services were generally provided by voluntary agencies, often with government subsidies. The newly developing Early Childhood Development Programs of the Health Commission represented promising strides toward community orientation and generic services; and the opening for Education Department activities in the area of early intervention meant that the importance of early education was acknowledged. However, co-ordination of services was lacking; there was uncertainty about the identification of children in need; and the sufficiency and quality of services would appear to vary widely by geographical location.

4.2.1
LIST OF EARLY INTERVENTION PROGRAMS (Victoria)

Government Departments

Health Commission

- Intervention Unit, Royal Children's Hospital
- Early Childhood Development Program, Southwest Region

Education Department - Special Services Division

- Special Developmental Schools (formerly Day Training Centres) for Intellectually Handicapped children operated by the Education Department
    - Oakleigh
    - Frankston

  - Noble Park
  - Yarrabah
  - Melton
  - Numurkah
  - Kallemondah

Tertiary Educational Institutional Programs

- Preston Institute of Technology, EPIC (OCC funded)
- Monash University, Krongold Centre for Exceptional Children
- Lincoln Institute, Parent Guidance for Profoundly Hearing-Impaired Children

Voluntary Agencies

Visually-Impaired

- Royal Victorian Institute for the Blind (Health Commission subsidies)
- St. Paul's School for Blind and Visually Handicapped

Physically Handicapped

- Shannon Park Spastic Centre (OCC funded)
- Spastic Society, Chelsea
- Yooralla Society

Hearing-Impaired

- Monnington (Education Department subsidies)
- McDonald House
- Parent Support Unit, John Pierce Centre
- Audiology and Pre-school Centre (Taralye) Advisory Council for Children with Impaired Hearing
- Princess Elizabeth Junior School for Deaf

Intellectually Handicapped

- Day Training Centres (subsidized by Health Commission)

  - Windarring
  - Kankama
  - Broad Insight Group
  - Mondani
  - Sunshine House
  - Kalparrin
  - Moorabbin
  - Peter Harcourt Centre
  - Karkana
  - West Gippsland
  - Mulleraterong
  - Wattle House
  - McCallum House
  - Wallara

- Day Training Centres
  - Malvern Play Group (OCC funded, Malvern Council M.R. and Physically Handicapped)
  - Handihelp Play Group (OCC funded, Board of Technical and Further Education)
  - Australian Centre for Brain Injured Children
  - Tehan House (Echuca and District Intellectually Handicapped Children's Association)

Autistic

- Mansfield Autistic Playschool (Commonwealth Health Commission funding)

4.3
EARLY INTERVENTION IN QUEENSLAND

Nineteen programs in Queensland provided detailed information about their operation and clientele. Of the nineteen, seven were conducted under the auspices of voluntary agencies. As is the case in the other states, government agencies were involved in early intervention in two ways: first, by establishing and maintaining programs; and second, by providing support in financing and/or staffing programs established by voluntary agencies.

Voluntary agencies, however, have led the way, in an historical sense, in providing early intervention programs in Queensland. Of the programs contacted, the oldest was that offered by the Association for the Preschool Education of the Deaf, established in 1953. Five years later the Queensland Sub-Normal Children's Welfare Association commenced a counselling service for the families of intellectually handicapped children under the age of five. This service was progressively expanded throughout the '60s with the appointment to the clinic team of a psychologist, a social worker and, finally, teachers.

In common with the other states of Australia, the major growth spurt in early intervention programs in Queensland occurred in the 1970s. The voluntary agencies commenced the following programs in that decade:

The W.R. Black Handicapped Children's Centre (1970)

The Catholic Educational Centre for Deaf Children (1974)

The Association for Childhood Language and Related Disorders (C.H.I.L.D.): Child Language and Behaviour Therapy Program(1976)

Spina Bifida Association of Queensland (1978)

Autistic Children's Therapy Centre (1979).

Agencies of the Queensland State Government also became directly involved in providing early intervention services and programs during the 1970s. The involvement of the Health Department's Intellectual Handicap Services Branch dates from 1970 when a team of social workers and psychologists began an assessment and family support service as part of a general program aimed at rationalizing institutional admission practices.

In 1973 the Queensland Department of Education's Guidance and Special Education Branch entered the field with home visiting and regular preschool integration programs for young visually handicapped children. The following year a two day per week centre-based early intervention program was introduced at the Narbethong School for Visually Handicapped children. This program was extended to five days per week in 1975.

An intervention program for young hearing-impaired children also was commenced in 1973 at the Cairns West Special Preschool Unit. Subsequently, this program extended its clientele to include visually-impaired children and those showing emotional disturbance coupled with language delay. Further early intervention initiatives with young hearing-impaired children were undertaken in 1974 in Rockhampton when the Education Department assumed control of a preschool originally commenced by a voluntary organization, and in 1976 in Mt. Isa with the establishment of a special education unit accepting children from the age of four years.

In 1978 an early education support group was established in Maryborough to service the families of children with a variety of disabling conditions. The same year, 1978, also saw the commencement of the first of the Queensland Department of Education Pilot Early Educational Intervention Programs(1) This program was the result of a decision to accept responsibility for the education of a group, predominantly comprised of young children with Down's syndrome, who had been receiving some intervention services since 1977 at the W.R. Black Handicapped Children's Home. The children were transferred to a unit at the Baroona Special School and the following year the program moved to a special preschool unit adjoining the Kenmore South State School. That year, 1979, also witnessed the extension of the Pilot Early Educational Intervention Program with the creation of special preschool units at Acacia Ridge, Aspley and Mt. Gravatt West, and the creation of an early intervention program for multiply handicapped children at the Cootharinga State Special School in Townsville. In addition, a playgroup in Mackay was extended to provide an early intervention program by co-ordinating the resources of the Guidance and Special Education Branch and Community Health Services.

With the passage of time early intervention services in Queensland have progressively moved from catering predominantly for children with clearly identified disabilities to include those with less easily categorized conditions rendering them developmentally at risk. The initiatives of the Intellectual Handicap Services Branch of the Queensland Health Department and the Guidance and Special Education Branch of the Department of Education have been directed increasingly to "filling the gap" by delivering early intervention services to children not falling within the traditional disability categories. These departments have actively endeavoured to meet the needs of those children not eligible to receive the services of specialized early intervention programs.

The degree of co-operation between the various government and voluntary agencies, particularly at the workface, was a noteworthy feature of early intervention emerging in Queensland. To facilitate this end, the Departments of Health and Education developed an informal network of referrals. The strength of the links, however, still depended on fluctuations in professional team memberships in each agency, and a sound partnership may have been jeopardized by the loss of a particular team member or as a consequence of other policy decisions made by either agency. The task of co-ordinating the use of each Department's resources at times was seen to be impeded by the existence of separate administrative and regional divisions across government departments. The need for co-ordination of services has been made more urgent by the policy restricting employment of medical officers, occupational therapists and physiotherapists to agencies of the Department of Health. An interdepartmental sub-committee with senior representatives from the relevant branches of the Departments of Children's Services, Education and Health has been established to examine ways of facilitating the better co-ordination of each department's resources in order to provide effective early intervention programs as well as avoiding unnecessary duplication of services.

Apart from direct involvement in providing early intervention services and programs, the Queensland Government provided financial and staffing support to the programs conducted by voluntary agencies. The Department of Education was most directly involved in providing this support. For example, the Association for the Preschool Education of the Deaf had the services of seven teachers as well as teachers' aides employed by the Department of Education. In addition, the Department provided transport to the program for some of the children and access to the services of guidance personnel. The Federal Government also provided the Association with financial support.

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(1) Hayes, A., Steinberg, M., Cooksley, E., Jobling, A., Best, D., and Coulston, A. Special Preschools: Monitoring a Pilot Project. Brisbane, 1981. (Draft report)

The Queensland Sub-Normal Children's Welfare Association was another agency that relied heavily upon funding from the Queensland Department of Education and the Federal Department of Social Security. The voluntary fund raising efforts of Association members were used to supplement the funds provided by the two governments. The Spina Bifida Association was also dependent upon the support of the Queensland Department of Education. The four teachers working at the W.R. Black Handicapped Children's Home at the time of the survey, were employed by the Department of Education on the staff of the Division of Special Education.

At least three programs, The Association for Childhood Language and Related Disorders (C.H.I.L.D.), the Catholic Education Centre for Deaf Children and the Autistic Children's Therapy Centre, were dependent on major funding from the Department of Social Security. With the exception of C.H.I.L.D. these programs also received support from the Queensland Department of Education. The programs provided by the Intellectual Handicap Services Branch were also heavily dependent upon Federal Government support.

The complexity of the funding of voluntary agency programs by government makes the division into government and voluntary programs somewhat arbitrary. While heavily involved in supporting voluntary agencies the State Government did not appear intent upon subsuming the program of voluntary agencies. Rather, as suggested earlier, government agencies were actively involved in developing complementary early intervention services and programs.

The aims and objectives, the target populations and the loci of intervention efforts differed distinctively between the two departments, Health and Education. The programs of the Intellectual Handicap Services Branch aimed to provide "family resource services" with the following objectives: direct assessment and therapy, provision of consultative services to other government agencies and to voluntary organizations, implementation of integration programs, establishment of resource centres, facilitation of family access to residential facilities and support for training and research programs. To achieve these objectives the Branch provided regional community services via clinics at Brisbane, Toowoomba and Rockhampton as well as a Family Education Unit in Brisbane engaged in skill training programs for the families of young handicapped children.

Home visiting by teams including occupational-, speech-, and physiotherapists, social workers and psychologists, was the predominant mode of early intervention service delivery to over 60 per cent of the families availing themselves of the Branch's programs. A further 35 per cent of the families received an integrated program (both home and centre-based) while only 4 per cent of families received services solely in a centre-based program. Fourteen full-time professional staff were involved in providing programs for 427 children, all of whom had mental retardation as their primary disability.

In contrast, the Queensland Department of Education has sought to "fill the gaps" by providing a set of "non-categorical" Pilot Early Educational Intervention Programs in addition to its programs for children with sensory or multiple impairments and disabilities. Four key principles guided the planning of the Education Department's Pilot programs:

- provision of planned education from the earliest possible age,
- close involvement of parents and family in the education process,
- keeping a wide range of educational options open for the child, and
- maximizing the opportunity of the child to experience a wide range of behaviour models.

(Ashby, Cliffe, Culbert & Miller, 1979)

The general aim was"to enable each child, whatever the handicap, to use each daily living experience to promote and enrich development and to maximize potential". (Ashby *et al.*, 1979). The programs were designed to be broadly developmental and to provide both home-based programs (particularly for infants and toddlers) and centre-based programs for older children (3 to 5 or 6 years of age).

The four Pilot Programs were given scope, within the broad guidelines, to develop the types of programs appropriate to their clientele and the available resources. The programs that evolved ranged from more structured approaches to intervention, showing the influence of the Macquarie University Program, to less structured, developmental stimulation programs. Within programs the developmental components emphasized varied considerably, depending on the specific mix of child disability characteristics evident at each centre.

The majority of children received either a centre-based program (64 per cent) or an integrated home and centre-based program (24 per cent). These figures are similar to the percentages for all Education Department intervention programs taken as a group (overall 68 per cent of children were in centre-based programs; 15 per cent were in integrated programs). While the Education Department's early intervention programs were developing home-based components, it is clear that the classroom remained the predominant locus of service delivery. In contrast, service delivery in the Health Department has been less tied to centre-based programs and the higher home-based component in the programs of the Intellectual Handicap Services Branch, in part, reflects this. Both approaches were open to some parent criticism, parents wanting more frequent visits from the Intellectual Handicap Services Branch teams and more sessions per week at the Pilot Early Educational Intervention Programs of the Department of Education.

The differences also reflected the differing interpretations of early intervention by the two agencies. The Intellectual Handicap Services Branch seemed to view assessment and provision of therapy as a major part of its early intervention initiatives. The Division of Special Education, in contrast, seemed to emphasize assessment and educational programming as the major areas of service. Both agencies also saw the provision of parent support as an important objective. The Education Department, however, tended to use the special preschool unit as the locus for parent contact supplemented by home visits, whereas the Health Department used the reverse strategy, emphasizing home visiting supplemented by parent meetings at a centre such as the Family Education Unit.

The majority of children (89 per cent) in the four Early Educational Intervention Programs had mental retardation as their primary disability, and this was also the case for the programs conducted by the Intellectual Handicap Services Branch. The two agencies differed, however, in the distribution of ages of children attending their programs. Only 21 per cent of the children receiving services from an Early Educational Intervention Program were younger than three years of age (and only 2 per cent were younger than one year old). For the Intellectual Handicap Services Branch the figures were 52 per cent of children aged less than three years and 15 per cent less than one year.

It must be realized, however, that the groups of children served by each agency were not mutually exclusive and, as such, the clientele statistics must be interpreted with caution. Many children were, in fact, receiving intervention services from both agencies. Others who had been assessed and participated in a home-visiting program from the Intellectual Handicap Services Branch were subsequently referred to a Pilot Early Educational Intervention Program. The process of intervention in these cases (and no doubt in many other cases) extended beyond the bounds of a single program within the ambit of one agency. Of course this may not necessarily constitute overlap.

The 108 children enrolled in Early Educational Intervention Programs received services from eight full-time teachers assisted by four aides and the part-time services of three guidance officers, four school medical officers from the Health Department's School Health Services Branch, four special preschool advisers, four speech therapists and two consultant physiotherapists from the University of Queensland.

It has been suggested by one voluntary agency, the Queensland Sub-Normal Children's Welfare Association, that State Government agencies (particularly the Education Department) duplicate the functions of the early intervention programs of the Association.

The Infant Stimulation Program offered by that Association aimed to provide therapy for the child, help for parents in developing intervention techniques and general family support. To quote from the Association's publicity material "the infant stimulation program is designed for 'at risk' children between the ages of birth and five years who come within the broad definition of intellectually handicapped. Mother and child attend a group program weekly." At the time of the survey, the programs were conducted by two itinerant teams comprising preschool home counsellors, physiotherapists, speech pathologists, psychologists and social workers, offering intervention services to families in Brisbane, at Toowong, Mt. Gravatt and Lawnton as well as in Beenleigh, on the Gold Coast, Nambour and Townsville. These teams included seven full-time personnel supported by a number of part-time workers and volunteers. One program was located in the Toowong Centre, five within the schools conducted by the Association and two were held in church halls. Centre-based programs served 65 per cent of the Association's clientele while 31 per cent received a solely home-based program.

Both the Pilot Early Educational Intervention Programs and the Infant Stimulation Programs provided a broadly based developmental program, covering sensori-motor, fine motor, communicational and personal social development. In total, 101 children participated in the Infant Stimulation Program. Of these, 53 per cent were younger than three years of age (with 5 per cent aged less than one year). In terms of the distribution of age groups served, the Association's clientele overlapped that of the Intellectual Handicap Services Branch more so than that of the Pilot Early Intervention Programs. All three agencies, however, shared a common feature in their programs. This was the predominance of children whose primary disability was mental retardation. In the case of the Infant Stimulation Programs, 83 per cent of the children receiving services were mentally retarded.

Overall, from the data supplied by programs, it appeared that in Queensland over 70 per cent of children in early intervention programs were mentally retarded, 13 per cent had sensory impairments (with hearing impairments having a higher incidence than visual impairments), 10 per cent were classified as multiply handicapped and 2 per cent as physically disabled.* The remaining children had a variety of emotional and communicational disorders.

It was also clear that although considerable initiatives have been taken to implement intervention as early as possible, fewer programs were able to serve the needs of infants than programs serving children in the three year to six year age group. It was also more likely that these services would be delivered in centre-based programs, predominantly located in South East Queensland. Most program staff expressed a desire to extend their services to younger groups of handicapped children and, with added financial support, to increase the home-visiting components of their programs. In so doing, the need has been recognized for avoiding unnecessary duplication of services. In the more isolated areas of Queensland the problem of provision of early intervention programs to young handicapped children remained a vexatious one.

4.3.1
LIST OF EARLY INTERVENTION PROGRAMS (Queensland)

Government Departments

Health Commission

- Central Assessment Clinic, Intellectual Handicap Services

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*(a) Data are lacking for the State pre-school program at Xavier Hospital, which was primarily for infants and young children who were physically disabled.

(b) The Queensland Spastic Welfare League offers treatment programs to cerebral palsied children from birth to 18 months and an intervention program for children aged from 18 months to 4 years. Detailed statistical data were, however, not available on these programs. The numbers of physically handicapped children listed as receiving early intervention, therefore, represent an underestimate. Services have been provided for cerebral palsied children by the Queensland Spastic Welfare League since the 1950s and these have focused on children from the time of identification of the disability. Thus, rather than services being a downward extension of programs for older children, the League has initiated early intervention programs tailored to the particular needs of their clientele.

Education Department

- Cairns West Special Preschool Unit
- Cootharinga State Special School
- Early Education Support Group, Wide Bay Region, Maryborough
- Mackay Early Childhood Intervention Program
- Preschool for Hearing Impaired, Rockhampton
- Townview Special Education Unit, Mt. Isa
- Narbethong School for the Visually Handicapped
- Xavier Hospital Preschool
- Special Preschool Units:
  - Acacia Ridge
  - Aspley
  - Ipswich
  - Kenmore
  - Mt. Gravatt

Voluntary/Private Parent-Support Group Programs

- Catholic Educational Centre for Deaf Children
- The Association for Childhood Language and Related Disorders
  Child Language and Behaviour Therapy Program
- Autistic Children's Association of Queensland, EIP
- Spina Bifida Association of Queensland, EIP
- Queensland Subnormal Children's Welfare Association
  Infant Stimulation Program
- The North Queensland Society for Crippled Children
  Cootharinga State Special School
- Queensland Spastic Welfare League
- W.R. Black Handicapped Children's Centre, Uniting Church
  Special Caring Services
- Friends of Brain-Injured Children (Centre in Melbourne)

4.4
EARLY INTERVENTION IN SOUTH AUSTRALIA

Of the early intervention programs identified, the greatest number provided services for children with intellectual disabilities. The Health Department's Intellectually Retarded Services played a major role, particularly in the provision for intellectually disabled children under the age of three years. Because an Education Department policy change in 1975 resulted in that department's provision of some education for handicapped children over three years of age through pre-school programs and other means, the Intellectually Retarded Services began to focus more intensively on the younger age group at that time. Whereas Intellectually Retarded Services' home visits in 1968-1969 were infrequent, by 1975 a home-visiting program by activity advisers, who gave information to parents and home-training directed to the child, was in full swing, with fortnightly visits within the Metropolitan area.

In brief, the home visits of the activity advisers were designed to assess the development of the child and plan an individual program to meet specific needs for sensory stimulation, motor development, self-help, language development, development of attentiveness and imitative ability, social development, and perceptual development. The philosophy underlying the service appeared to support a low-key program of assisting parents to help their children develop through play. The activity advisers brought toys, and demonstrated ways to set up learning situations through the use of toys and materials found naturally in the home environment.

Homes in country areas were visited on an average of only three times a year, and the limited nature of the service was a concern of Intellectually Retarded Services staff. In some remote areas, service was provided by correspondence only.

In addition to the home-visiting service, activity advisers, along with paramedical aides and physiotherapy staff, provided a playgroup service. An Activity Adviser (the name may be changed to 'Educational Adviser') led a playgroup once a week for a few hours (fortnightly in one location). The playgroups were attended by parents and children and in all, there were four playgroups in a variety of locations. Individual programs of stimulation by physiotherapists or aides were frequently given to some children while others participated in structured group activities. Although there was a great deal of communication between physiotherapy and activity advisory staff, physiotherapy services were handled administratively by a separate department.

For severely affected children, the Intellectually Retarded Services Bresle House Day Care Centre (for totally dependent intellectually handicapped children over the age of three) offered a stimulation program teaching such skills as feeding and toileting. Although early intervention has traditionally been considered important in terms of eventual integration, the Bresle House program was one of a number of programs for severely handicapped children in which early intervention was viewed as a means of helping children to achieve skills which would 'normalize' the child, to the greatest degree possible, without the expectation of preventing institutionalization.

Another Health Commission program was run by the Port Pirie Handicapped and Retarded Children's Centre at Port Pirie Hospital. This was a day care program that involved more than what is usually termed day care. Individual programs of speech therapy and physiotherapy were offered as well as gymnasium activities, musical games, lunch-time feeding programs, group play activities to teach a variety of skills, and activities in the community (swimming, picnics, other outings). This program exemplified sound co-operation between Education and Health Departments in that a teacher from a Special School participated and therapy was provided by staff under the direction of other organizations such as Adelaide Children's Hospital, Woodville Spastic Centre, and Regency Park. The program operated one day per week. Seven children who were three years of age or under were served by this multidiagnostic program operated in a medical setting. Administratively, the program staff were immediately answerable to the nursing administration. The Port Pirie program appeared to be one that developed to meet a specific community need, and the community orientation was notable.

A similarly community-oriented program, under the aegis of the Education Department, was the Mansfield Park Junior Primary School integrated Playgroup. It began with three handicapped and six non-handicapped children meeting twice weekly. The aim was to prepare children with disabilities for pre-school. Also 'multidiagnostic' in nature (accepting children with any of a variety of disabilities) the school provided both group and individual activities. The principal of the junior primary school obtained the services of Intellectually Retarded Services' psychologists and physiotherapists to assist in the planning and management of the group.

The Education Department made some provision for handicapped children over the age of three and provided peripatetic teacher support through the special pre-school at Kent Town. Children from various parts of Adelaide attended and about 34 children were served in 1979. Referrals came from a variety of sources including the Adelaide Children's Hospital, Intellectually Retarded Services and the Woodville Spastic Centre. The two teachers at Kent Town spent Monday, Tuesday and Wednesday of each week at the preschool and Thursday and Friday in support work at integrated facilities. Physiotherapy staff from Intellectually Retarded Services provided physiotherapy services. More recently they assessed children once a term and advised the teachers on activities to incorporate into the regular program to meet the child's needs. The Education Department also had services for visually and hearing-impaired children under three.

The special service provided for handicapped children through the Whyalla Early Childhood Co-ordinating Committee is of interest partly because it was a community project making use of generic community resources to provide for children with disabilities. A field worker at the Resource Centre had, since 1973, offered a service to twelve children up to age five. An informal survey by the Whyalla Early Childhood Co-ordinating Committee established a need, and a home-based program was provided, as well as a weekly playgroup that was based at the Technical College. Two staff members had teaching backgrounds, and the program also involved an itinerant physiotherapist and a domiciliary care service from the hospital serving the community.

The Woodville Spastic Centre offered both a nursery and a Kindergarten program operating 30 hours per week with input from physiotherapists, psychologists, teachers, social workers, speech pathologists, occupational therapists, and nurses and aides who assisted the team in a close work relationship. Daily notes were used to communicate with parents, and they visited the centre frequently (with almost half of the parents visiting fortnightly). At least two home visits were made each term. The Centre serviced children throughout South Australia, some of whom travelled a considerable distance to attend, the journey taking as long as one and a half hours for seven weeks under the direction of psychologists. Bi-monthly parent nights were held, and mothers of nursery children met with each other monthly while their children were involved in playgroup activities.

The remaining programs associated with voluntary associations were for children with intellectual disabilities. The Developmental Learning Program for Young Down's Syndrome children, supported by Down's Syndrome Children Incorporated, provided a playgroup, individual programming, and some home visiting, co-ordinated by a teacher who had the assistance of volunteers and of teachers from the Special Education Program at the Adelaide College of Advanced Education at Underdale.

Kate Cocks Memorial Family Services Incorporated provided a centre-based early intervention program (and a home-based program for two children) staffed by two persons. Established by the Methodist Church, the program emphasized developmental concepts. A pre-school model of 'educational day care' was evident and staff described the program as more than a day care centre in its service of parent relief and child-minding for totally dependent children. The program focused specifically on the Southwestern region, and included totally dependent, moderately to severely affected children, between birth and 6 years of age. The region served was quite large, however, and staff expressed an interest in extending the service to other locations. As in other programs, children who attended the Kate Cocks program may also have been served by other agencies such as Intellectually Retarded Services. The intention of the Kate Cocks project was to provide support enabling parents to keep their children at home, a purpose that has been increasingly seen as important in South Australia as elsewhere in the nation. Transport was by public cars or an ambulance and although this was a regional service, journeys could be quite long. Parent involvement was considered very important, and workshops and parent courses were held for training purposes. Children attended from one to five days per week.

A number of other volunteer agency programs were contacted by the research team. The Barkuma Central Districts Mentally Handicapped Children's Association provided a program for ten handicapped children under the age of six. It was a kindergarten type of program with emphasis on self-care skills. The Suneden School also served children with mental disabilities, and offered a playgroup for children from birth to 4 years, and pre-school training. It was sponsored by the Suneden Retarded Children's Welfare Association. One other program of early intervention was supported by the Mentally Retarded Children's Society. It was a Home Liaison service, providing liaison between parents and services, but it also provided home-based assistance, teaching parents to teach children, where services were not available.

There were a number of broad intervention activities or related services in South Australia. For example, the Health Department's Intellectually Retarded Services not only provided early intervention, as more narrowly defined, but also was involved in a number of other activities. The Intellectually Retarded Services Diagnostic Clinic, located at Cromond House, provided assessment and referral services, but not early intervention per se. The Intellectually Retarded Services Family Training Unit provided training opportunities for parents in a variety of areas related to behaviour management and skill development. Although there was little or no direct contact between the professional and the child, the purpose of the program was to train parents more effectively to manage and to teach their children. The Skills Training Workshop, for example, taught parents a way to design and implement a structured program to teach their children a new skill in the home environment, to use a developmental checklist to assess their children, to formulate a behavioural objective and make a task analysis of the skill, to reinforce appropriate behaviour, and to record their activities accurately. The 20-hour (10 two-hour sessions or 5 two-day sessions in the country) workshops were held not only at the Family Training Unit but at special schools in the city and country. Very specific skill training programs (toilet training, feeding) were also provided. Behaviour management courses consisted of 3 hour sessions over a period of 10-13 weeks. It was planned to develop language acquisition workshops in 1980, studying their usefulness to parents and children.

The Infant Development Project, although not operational at the time of our site visit, should be mentioned because it represented a program that was developed co-operatively between staff members of the Health (Intellectually Retarded Services) and Education (Special Education) Departments, funded by the Office of Child Care, and designed to meet research aims as well as service to parents in planning and implementing developmental programs for their own children. Problems it faced were at least partly due to the research orientation which required, for purposes of proper experimental controls, that children in the program participate exclusively in that program.

There were a number of diagnostic, treatment, and referral services, integrated generic programs, family support services, and resources for children with disabilities in South Australia. The Adelaide Children's Hospital, especially its Child Development Clinic (previously called the Cerebral Palsy Clinic) offered assessment, and other departments, such as physiotherapy, occupational therapy, psychology, and speech therapy, offered treatment programs for young handicapped children. The occupational therapy and physiotherapy departments with the assistance of the speech therapy department were, at the time of a site visit, in the early stages of providing a language development clinic with attendance on a fortnightly basis. Programs offered by the hospital also catered for children whose disabilities did not fail into the categories of 'handicap' as it is frequently understood; for example, the clumsy child. Although generally the clientele did not include children with 'traditional' handicaps, it was interesting to observe that the concept of intervention in this medical setting was developmental and assumed the importance of diverse skills (gross motor, fine motor, perceptual, cognitive, communication and social) as well as parental guidance and support to the family. Much of the program's activity took place with in-patients, but out-patients were also served. Because the Child Development Clinic involved not only hospital staff but also representatives of other service groups (Crippled Children's Association, The Spastic Society, Education Department, Intellectually Retarded Services and others) it was in a position to play a co-ordinating role. The hospital also had a Spina Bifida Clinic that was providing assessment and treatment of handicapped children, and a psychiatric department which also offered services for young handicapped children and their families.

The Children's Assessment Team of the Flinders Medical Centre offered multidisciplinary assessment of children and families with developmental problems. As one staff member explained to us: 'We do not provide an intervention program as such, but do offer a wide range of therapy and intervention based on the assessment of each child and family'. These comments underline the difficulty of defining an early intervention program. The occupational therapy department at the Centre, for example, offered a program that shared many characteristics with early intervention programs per se.

Hospitals in South Australia played a diversified role in providing service relevant to early intervention. For example, the Madbury Hospital offered paediatric assessment and "Well Baby' Clinics were located at the Queen Elizabeth and Queen Victoria Hospital, which also had an 'at risk' clinic. Some country hospitals also provided significant services relevant to early intervention; for example, Port Pirie Hospital offered a day centre for handicapped children. In addition special programs of therapy applicable to handicapped children were available at the Port Lincoln and Broken Hill Hospitals.

Other agencies providing assessment services included the Child Guidance Clinics and Mitchell House Mental Health Services, the National Acoustics Laboratory, the Deafness Guidance Clinic and the Audiology Unit of Adelaide Children's Hospital, the Education Department's Guidance and Special Services branch, and The Mothers and Babies Health Association. The Mothers and Babies Health Association also provided such services as advice to mothers with feeding, sleeping and management problems and offered an advisory service to playgroups.

The Education Department provided services for children with visual and hearing impairments under the age of three. The opportunity for parents and children to visit the Townsend pre-school once a month was provided. Teachers also visited the home to give advice on assisting the child in learning, in gaining mobility and in making social contacts. No centre-based program for very young children was available. The Education Department provided a parent guidance service for hearing-impaired children, to advise parents through home visits or parent visits to the Ashford Centre where the Special Education Resource Unit was also located.

The South Australian Oral School provided services to the hearing-impaired and was described in 'Services for Teachers and Parents of Hearing-Impaired Children' as having a playgroup, individual guidance sessions in a simulated home environment which provided the advantage of the home setting without a loss of privacy to parents, and a home-visiting program at parental request, in order to help parents to assist their child's early development. The playgroup was an integrated one using activities such as those found in kindergartens to help the child develop communication and other skills.

The Kindergarten Union of South Australia, a statutory authority, provided a service for all children; it accepted children with disabilities in its regular programming and supported kindergarten staff and children and their families with a Special Services Section. Special services included assessment, remediation and a consultative service to pre-schoolers, kindergarten staff and parents throughout the state. Speech pathologists, psychologists, special educators, social workers and a medical officer comprised a multidisciplinary team to deal with a wide range of problems: educational, emotional, behavioural and social. In 1979 the total number of children (who were mostly between 3 and 5) referred to the Special Services Section represented about 8 per cent (1346) of total enrolments in Kindergarten Union Centres in ten regions (nine in metropolitan areas and one in the country). Most of the referrals fell into the 'borderline' areas of disability such as speech and language disorder (about 38 per cent), behaviour management problems (about 11 per cent), family problems (about 9 per cent) and slow development (8 per cent). Children with physical handicaps, sensory impairments, and mental retardation together made up a very small percentage of referrals.

One of the significant issues related to early intervention concerns family relief. Some services provided for young children with disabilities permanent or casual day care, support to parents, and professional services for a fee comparable to that of other subsidized day care centres. One facility catered for any handicapped child from birth to three years of age and severely handicapped children over three. This program operated five days a week, initially from 9:00 to 3:30 p.m. with plans to extend those times from 8:00 a.m. to 6:00 p.m. to help working parents. This service represented a development that would appear to be very important: an enriched day care service, supported by a local community which attempts to exploit the resources of the community through effective liaison to develop appropriate programs to meet children's needs.

The Mentally Retarded Children's Society (now comprised of "Gateway" and "Arana Industries"), which provided the Home Liaison Service listed as an early intervention program, also supported the Rachel Child Care Centre open to mentally-impaired children over four months of age up to pre-school age.

Mentioned last - but by no means of least importance - are toy libraries. Some toy libraries were adjuncts to other services. Examples, for young handicapped children, were the Kindergarten Union toy library, the Strathmond Centre toy library, and the Special Education Resources Unit, an

Education Department service used by special schools and available to children with special needs in regular schools as well. The Torrens Toy Library at Adelaide College of the Arts and Education at Underdale was open to the community for referrals of children with disabilities of any kind. There were, of course, toy libraries for the general community, which could provide toys for handicapped as well as non-handicapped children. The toy libraries with specialized attention to children with disabilities, however, provided a unique service by including advisory services that enabled a parent to encourage the child to play and to develop through play. Toy libraries served older children as well, but were predominantly a significant resource for very young children who were a major segment of the clientele.

Other associations and groups also played an ancillary role. For example, the South Australian Institute on Developmental Disabilities Incorporated, an independent co-ordinating body, represented 18 major agencies serving the mentally retarded in South Australia, functioning as an information source and providing impetus for research. The Institute published a directory of services to intellectually handicapped children that had been compiled by the Family Training Unit.

In summary, three salient features characterized the pattern of early intervention services in South Australia. First, both the state Departments of Health and Education were actively involved in providing early intervention programs. Second, there was considerable evidence of the successful co-ordination of the services delivered by both agencies, as well as between these agencies and non-government organizations. Finally, there was an extensive network of assessment services available to support intervention programs. Taken together, these three features represent a sound basis for the further development of a well articulated, co-ordinated set of early intervention services in South Australia.

4.4.1
LIST OF EARLY INTERVENTION PROGRAMS (South Australia)

Government Departments

Health Commission

- Intellectually Retarded Services Activity Adviser Service and Playgroups; Physiotherapy Service (intellectually handicapped)
- Intellectually Retarded Services Bresle House Day Care Centre (intellectually handicapped)

Education Department

- Whyalla Early Childhood Resource Centre (84 Lockhart Street, Whyalla 5600) Special Program for young handicapped children
- Kent Town Pre-school (in co-operation with Intellectually Retarded Services (intellectually handicapped)
- Townsend Pre-school for Hearing and Hearing-Impaired Children
- Mansfield Park Junior Primary School Integrated Playgroup

Department of Community Welfare

- No early intervention programs per se offered

Tertiary Educational Institutional Programs

- No program was offered by a tertiary institution per se, though there were close ties between the Adelaide College of Arts and Education at Underdale, the Autistic Children's Centre and the Torrens Toy Library, and the South Australian Institute on Developmental Disibilities based at the Adelaide College at Underdale. The Developmental Learning Programme for Young Down's Syndrome Children in South Australia although supported by Down's Syndrome Children Incorporated, was based at Adelaide College of Advanced Education at Underdale, and the educational advisers of the program were lecturers at the college. The program commenced in 1979.

Voluntary/Private Group Programs

- Mentally Retarded Children's Society, Home Liaison Officer Service
- Suneden School, Suneden Retarded Children's Welfare Association
- Kate Cocks Memorial Family Services, Incorporated Day Care Program (totally dependent children), Methodist Church
- Developmental Learning Program for Young Down's Children
- Barkuma, Central Districts Mentally Handicapped Children's Association
- Woodville Spastic Centre (Nursery and Kindergarten), South Australia Paralysis Welfare Association Incorporated.
- Regency Park Centre, Pre-school Crippled Children's Association
- Autistic Children's Association, the Community Based Program
- Port Pirie Handicapped and Retarded Children's Centre

Activities Broadly Defined as or Related to Early Intervention

- Intellectually Retarded Services Diagnostic Clinic, Cromond House
- Intellectually Retarded Services Family Training Unit
- Infant Development Project
- Adelaide Children's Hospital
- Flinders Medical Centre
- Madbury Hospital
- Queen Elizabeth Hospital
- Queen Victoria Hospital
- Port Pirie Hospital
- Port Lincoln Hospital
- Broken Hill Hospital
- Child Guidance Clinics
- Mitchell House Mental Health Service
- National Acoustics Laboratory
- Deafness Guidance Clinic
- Mothers and Babies Health Association

- Guidance and Special Education Branch
    - (a) Child Parent Centres
    - (b) Visiting Teacher Service for Visually Impaired (based at Townsend School)
    - (c) Parent Guidance Service for Hearing Impaired

- South Australia Oral School
- Kindergarten Union of South Australia
- Seawinds Day Care Centre, Christies Beach
- Rachel Child Care Centre, Mentally Retarded Children's Society
- Kindergarten Union Toy Library
- Strathmont Centre Toy Library
- Special Education Resource Unit
- Torrens Toy Library
- South Australian Institute on Developmental Disabilities

4.5
EARLY INTERVENTION IN WESTERN AUSTRALIA

The multiplicity of pre-school facilities available in Western Australia meant that the network of services was likely to take many different forms for individual children. Children and their families followed a course of differing program types depending upon the source of the initial referral, the family's knowledge of services, the guidance of professionals and the child's handicap.

Most early intervention programs in Western Australia were financed and administered by government departments. The four main programs run by non-government agencies were The Speech and Hearing Centre for Deaf Children, The Spastic Welfare Association, The Exceptional Children's Project at the University of Western Australia and the Mildred Creak Autistic Centre. However, these agencies receivedthe major part of their funding from government departments. It was, therefore, easiest to describe early intervention services in Western Australia by categorization of handicap rather than by the programs' administrative and financial structures.

Children were likely to start to receive early intervention services through short term assessment periods at the Child Development Centre (Child Health Services), Princess Margaret Hospital, The Exceptional Children's Project (a University of Western Australia research project originally funded by the Office of Child Care and later funded by the Early Childhood Branch of the Education Department), Department of Education's Guidance Branch or at Irrabeena (Division for the Intellectually Handicapped). Some children remained under the supervision of these services for extended periods of observation, assessment and treatment whereas other children were referred to one of a number of services. If the child's handicap could be easily placed into one of the major categories of handicaps, it was likely he would then be referred to a program catering for such a handicap.

Children considered to be intellectually handicapped were most likely to receive services from the Division for the Intellectually Handicapped (Department of Health) or from the Education Department. Many children received services from both these government departments. Children with other handicaps such as visual impairment, auditory impairment, physical handicaps and autism were catered for in separate programs. Many of these programs, regardless of type of handicap, had a home-based component for the younger children and babies and a centre-based component for the older pre-school children. Of the centre-based programs, many were located in schools which could then provide a program beyond the age of five. The home-based component of programs depended upon professionals being able to visit the home frequently. While frequent home visiting and centre-based programs were available for most parts of metropolitan Perth, less choice was available for rural Western Australia where the geographical distance is such that teams of therapists could only hope to visit areas at infrequent intervals, if at all.

As was the case in other states, children with intellectual handicaps formed the largest category of children receiving early intervention services in Western Australia. Most children who were identified by Guidance Branch staff, general practitioners, paediatricians, neurologists, hospital staff or parents as possibly being intellectually handicapped were referred to Irrabeena. Irrabeena offered a unique style of service delivery in Australia with its comprehensive range of services and facilities which included social trainers who visited homes and worked with children on a one-to-one basis in the centre-based programs. All new referrals were initially seen at Irrabeena, which also functioned as a co-ordinating centre for the community facilities, and as a hub for the services offered by the regional centres. Each regional centre offered both home-based and centre-based programs. Most of the home-based programs involved children younger than three years, although some supplemented the experience of older children who attended centre programs. The Division for the Intellectually Handicapped's unique system of social trainers was used for skill training at the centre-based programs as well as for parent skill training during home visits. The staff of each regional centre was organized as a team, responsible for service delivery in its defined geographical area. The Division for the Intellectually Handicapped's early intervention service provided a model of a comprehensive network of service delivery.

Western Australia's multiplicity of services was reflected in the fact that most, but not all, children with intellectual handicaps received early intervention services through the Division for the Intellectually Handicapped's comprehensive range of services. In conjunction with the Kindergarten and Child Study Centre at the University of Western Australia, the Exceptional Children's Project was established for handicapped pre-school children. Some children with intellectual handicaps attended this centre-based program. The aim of the program was to give children training and experience which would help them to cope with their problems when in 'normal' situations. This project was considered to be experimental in nature and provided research and training opportunities for students. The Department of Education had a pre-school class which was part of a special school for intellectually handicapped children at White Gum Valley Special School. These children were accepted upon referral after assessment. Most referrals came from the clinics conducted by the Division for the Intellectually Handicapped and there was an overlap, with many children attending both the special pre-school group and therapy centres organized by the Division for the Intellectually Handicapped. As the Division had a strong commitment to normalization, many of the moderately and mildly intellectually handicapped children were referred directly to the Early Childhood Branch for special case placement in regular pre-schools. There were also many intellectually handicapped children who had been enrolled by parents in playgroups, day care centres, private kindergartens, or other facilities. However, most children were known to the Division for the Intellectually Handicapped even though there was no formal registration of intellectually handicapped children in Western Australia.

The Catherine McAuley Centre was an example of a private organization with government subsidies which provided a centre-based program and occupational therapy sessions for a small group of pre-school children with mental retardation as their major disability. The Western Australian Council for Special Education's booklet, "The Education of Intellectually Handicapped

Children in Western Australia" (1979) provides a detailed description of the historical development of services and the current administration of services for intellectually handicapped children.

Services for visually-impaired pre-school children have existed since 1974 when a pre-school centre was added to the primary school at the Sutherland Blind Centre. Regardless of age, once visual impairment had been diagnosed, children could be enrolled in a special program. This program was not restricted to those children who required braille education. Further, it was also open to visually-handicapped children with multiple handicaps who might be attending other institutions. Parents of visually-handicapped pre-school children from country areas were encouraged to attend the centre for educational advice at any time and to stay at the flat attached to the Centre. Services for visually-impaired children are described in the booklet of the Western Australia Council for Special Education, 'Education of Visually Handicapped Children in Western Australia' (1978).

There were two main services in Western Australia for children with hearing impairments: the Hearing Assessment Centre and the Speech and Hearing Centre.* The Speech and Hearing Centre had three integrated kindergarten school rooms. The centre was committed to the oral/aural, supplemented by cued speech, philosophy of teaching hearing-impaired children and hence placed major importance upon early identification followed by early intervention services. This program was predominantly a centre-based program with approximately one third of the children attending the pre-school being hearing-impaired. Most of these children would later attend the primary school at the Centre.

Many children with physical handicaps received programs organized by the Spastic Welfare Association. This Association provided mainly centre-based programs. No home-based programs as such were offered, but some home services were provided by co-ordination with occupational therapists and social workers from Princess Margaret Hospital. The association provided both residential services and day programs. Separate programs existed for the two year olds and for the three to four or five year olds. Approximately half of the children who attended these programs were physically handicapped and the remaining half could be considered to have mental retardation as their primary disability. Another program which catered mainly for children with physical handicaps was the Child Development Centre, where the physiotherapy program involved 39 pre-school children with physical disabilities.

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* These services are described in a booklet of the Western Australian Council for Special Education: 'Education of Hearing-Impaired Children in Western Australia', 1976. While there is a description of the procedure for children who are referred to the Hearing Assessment Centre, there is no description of the early intervention service offered by The Speech and Hearing Centre.

The pattern of services in Western Australia was dominated by the extensive operations of the Division for the Intellectually Handicapped, but other government and voluntary agencies made substantial contributions also. Considerable difficulties were noted in providing assistance to handicapped children in remote areas of this large state.

4.5.1
LIST OF EARLY INTERVENTION PROGRAMS (Western Australia)

Assessment, Guidance and 'Short Term' Programs

- The Child Development Centre (Child Health Services), Community Health Program
- The Princess Margaret Hospital
- The Exceptional Children's Project (University of Western Australia) (Financed by Early Childhood Branch)
- The Guidance Branch of the Education Department
- The Division for the Intellectually Handicapped, Irrabeena Central Office

Intellectually Handicapped Children

Irrabeena

- Southeastern Region (Gosnells)
- Southwestern Region (Fremantle)
- Northern Region (Elwyn Morey)
- Eastern Region (Pyrton)
- Special Day Care Centre - multiply handicapped
    - Resident Hostels, Pyrton, all ages
    - Special Care Hostels, 6 in total, all ages

Education Department Pre-schools

- The Balga Special School
- The Millan Pre-school
- The White Gum Valley Special School (originally funded by the Office of Child Care)

Early Childhood Services Branch of Education Department*

- Pre-schools attached to schools for other exceptional children
- The Exceptional Children's Project (University of Western Australia)
- Two experimental groups at Lathlain and Tarcoola.

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* Assists with placement of 'special needs' but is mainly concerned with the intellectually handicapped.

Visually-Impaired Children

- The Education Department, Sutherland Street Blind Centre
- Royal Western Australia Institute for the Blind

Auditory-Impaired Children

Education Department/Private

- Integrated pre-school at The Speech and Hearing Centre (Early Childhood Branch)

Hearing Assessment Centre

- Parent Guidance (0 to 3 years)
- Cottsloe Special Kindergarten (3 to 5 years)

Physically Handicapped Children

Spastic Welfare Association

- Sir James Mitchell School (run in conjunction with the Education Department)

Education Department Pre-schools

- Buckland Hill Special School (jointly run with the Crippled Children's Society)
- Willeton Special School (jointly run by the Education Department and the Public Hospital)
- Koondoola Special School

4.6

EARLY INTERVENTION IN TASMANIA

Early intervention programs in Tasmania which reported and came under the definition employed in this review numbered eleven. These were operated almost entirely by government bodies responsible for health education services. Within these 11 centres, 223 children received assistance, of whom 15 were less than 2 years of age, 55 aged 2 to 4 years, 43 aged 4 to 6 years, and 110 were aged over 6 years. The large number of children who fell into this latter age group should be noted.

The children were experiencing a range of disabilities: physical (86), intellectual (60), visual (7), hearing (12) and multiple handicaps (27). Almost all services were centre-based. Only 5 families/children were receiving support within their own homes.

The staff of these Tasmanian programs were predominantly teachers (10). Other staff included speech therapists (6), physiotherapists (5), psychologists (5), occupational therapists (4), and social workers (3). Of the total staff of 38, only 9 were full-time, all others being involved with these programs on a part-time basis. This position highlights the add-on nature of these Tasmanian early intervention programs. In addition to the above, aides, and a physical educator, nurse, guidance officer and music therapist were also involved in contributing to early intervention programs.

The actual agencies providing the programs ranged over health and education provisions. At the non-government level the Lady Gowrie Child Centre provided an after-work program for four children. Education Department programs were operated at the Bruce Hamilton School (8 children), the Lady Rowallan School (a total of 20 children in two groups), the Motor Development Program (11 children) and the Warrane Kindergarten group (10 children), all in the Hobart area; and at the Language Unit (6 children) and St. Michael's School (9 children) in Launceston.

Health Department programs were limited to a parent-baby group (6 children) at 'Elonera', Lauceston, 26 children who were in attendance at an early intervention program at Quindalup Day Training Centre in Hobart, and the largest Tasmanian program, operated at the Douglas Parker Rehabilitation Centre (123 children).

Overall, early intervention services in this State presented as being fragmented. They divided between health and education authorities, and were mainly add-on programs to existing services, which were for children of school age but with younger children also being catered for. There was considerable evidence of a lack of communication between programs, and information about programs.

Few of the services provided a home-based component within a centre program, and where this did occur there was a concentration of this type of service in programs for physically handicapped children. There was also lack of emphasis on family support, a crucial element in early intervention programs.

One major problem was the temporary nature of staffing and of programs, due to the limited number of sources of ongoing funds. Many staff also lacked qualifications adequate to their needs, and to the needs of the families and children.

4.6.1

LIST OF EARLY INTERVENTION PROGRAMS (Tasmania)

Government Departments

Department of Health

- 'Elonera' Handicapped Children's Centre
- Quindalup Day Training Centre
- Douglas Parker Rehabilitation Centre

Education Department

- Language Intervention Program
- Bruce Hamilton School
- Lady Rowallan School
- Motor Development Program
- Warrane Kindergarten
- St. Michael's School, Launceston

Voluntary/Private

- Lady Gowrie Child Centre
- St. Giles Home, Launceston
- Miranbeena, Royal Children's Welfare Association, Burnie

4.7
EARLY INTERVENTION IN THE NORTHERN TERRITORY

It was only recently that early intervention services were established as clearly defined services in the Northern Territory. The services were, therefore, still very much at an early developmental stage and many plans were only in the process of starting to be implemented. Every endeavour was being made at an executive level of government to co-ordinate the developing services of Health, Education and Welfare, and voluntary agencies. The Department of Community Development commissioned the Tipping report which became the main guideline for the development of services. This report was the result of a rapid increase in concern for providing early intervention services in the Northern Territory and represents the Government's intention that the developing services be co-ordinated.

The increasing concern for services for handicapped pre-school children was very apparent in the number of services which have been established in the last couple of years. The establishment of The Down's Syndrome Association seems to have been a very important historical step for the development of early intervention services. The forming of The Down's Syndrome Association was the result of a group of mothers of Down's syndrome babies meeting regularly as a coffee group and then forming an Association. Four mothers had originally been introduced to each other four or five years ago by a clinic sister who suggested that the mothers come to her clinic at the same appointment time. This was basically the beginning of the group, and in 1980 a constitution was framed for the Association. The focus of The Down's Syndrome Association was upon providing an early intervention service within the existing pre-school services, and its aim was complete integration. The Association formed its ideas in the early stages of its development by contacting programs within Australia, such as those at Macquarie and Monash Universities, as well as writing to universities and early intervention programs overseas. The Association placed importance upon giving parents the skills to work with the child, rather than having specialist groups with professionals working with the child. It was felt by the Association that Darwin was in a unique situation because of its isolation and that, as a result of distance from services and resources, and the large turnover of professional staff as well as a very mobile general population, it was only by giving the parents the appropriate skills that any continuity of service could be assured for the child.

A particularly important development in the services for children with hearing impairments has also occurred in the last couple of years. The effects of the establishment of the National Acoustics Laboratory (NAL) plus the establishment of a register of handicapped children in the Northern Territory, by the Department of Health, has meant that many children with hearing impairments are now being identified at an earlier age. These two factors plus an increase in the population of the Northern Territory meant that the Department of Education's Stuart Park Primary School had not only a unit for primary school-aged children with hearing impairments but also an early intervention program which had places for four handicapped children and eight places for non-handicapped children. This early intervention program had a commitment to working with children at the centre rather than in the children's homes and, as well as there being a teacher of hearing-impaired children at the school, there were also two or three visiting teachers employed by the Department of Education who helped to co-ordinate programs with the NAL and regular school placements for hearing-impaired children.

Early intervention services in the Northern Territory were most clearly defined for children with Down's syndrome or a hearing impairment. Although the Spastic Centre's early intervention program was designed to cater for children with physical handicaps and cerebral palsy, only a small number of the children had cerebral palsy and the Spastic Centre actually provided a program for a wide range of disabilities. The Spastic Centre offered a program which had a one hour per day program and a once a week home-visiting program. Services for specific handicaps were very new in the Northern Territory and services had not developed upon the same categorical bases as in other States. The Spastic Centre was a good example of this difference. The low numbers of children who possessed any particular handicap made it inappropriate to establish separate services for each handicap category. For instance, the Department of Education established places at the Tiwi Pre-school for children with visual impairments, with the aim being for the service to be modelled upon the services in existence for hearing-impaired children. Last reports, however, indicated that only one child with a visual impairment attended this pre-school. The Department of Education had attempted to provide both this service and its service for hearing-impaired children by extending its existing service downwards to include pre-school-aged children.

Although there has been a rapid increase in services in the last few years with more developments intended as a result of the Tipping Report, early intervention services in the Northern Territory presently can be described as existing only in Darwin and Alice Springs.

The isolated and scattered population characteristic of the Northern Territory had considerable impact on the types of services which children could receive. Resources had to be found within the communities or else obtained by short-or long-term importing of expertise. Stories of families who needed to move from the Northern Territory to obtain services for their children were frequently told to us during our contact with parents and staff. However, this was more the case in the past than in recent times. The development of services had been very much in a state of flux at both a government and voluntary service level and it was only recently that the situation gradually became crystallized and programs and service delivery structures were set up. The Tipping Report, and plans for its implementation, were seen as being crucial for the development of a structure of services. Services and resources currently existed which supplemented the early intervention programs already described but the services were very fragmented. However these fragmented services were seen to be particularly important for Alice Springs because no early intervention program as such existed. The Alice Springs Municipal Council had a Children's Service officer who was responsible for the development and co-ordination of children's services. He endeavoured, for the past two years, to establish a Toy

Library Service in Alice Springs to co-ordinate with the Darwin Toy Library Service for the Northern Territory. The establishment of the Toy Library Service in Alice Springs was seen as providing an avenue for those parents who were anxious about their children but unwilling to ask for professional help. Although the toy library would be like the Darwin Toy Library and would not be specifically for handicapped children, the staff would have knowledge about atypical children and the services available for such children in the Northern Territory. The Alice Springs Spastic Council was working on plans for the development of a facility in Alice Springs. This facility would include a Day Centre as well as an early intervention program. The Spastic Council intended to offer the service to all handicapped children and not just to cerebral palsied children.

In an attempt to provide as much stimulation of back-up resources as possible, The Down's Syndrome Association sometimes arranged for workshops to be taken by organizations, such as the Family Training Unit in Adelaide, outside of the Northern Territory. However, the general opinion seemed to be that regardless of how valuable workshops were, stimulation and reinforcement needed to be on a monthly basis rather than once or twice a year, and that a more effective network of services and resources could be provided if all government and voluntary resources were co-ordinated at a local level. This was also one of the recommendations of the Tipping Report.

The Education Department Special Services took responsibility for the identification of children for educational placement, but its role as a back-up resource for programming was still being developed. The Department of Health and the hospitals at Darwin and Alice Springs also provided a back-up resource for staff in early intervention programs, parents and administrators but, as with all services currently in the Northern Territory, the resources had developed in a piecemeal fashion and the effectiveness of the network was very much a reflection of the person contacted rather than the network of services itself.

In summary, although services in the Northern Territory were relatively few when counted as discrete programs, there were many instances of the provision of early intervention services by flexible allocation of existing community resources, and by the co-operation of government departments. Unfortunately, outside the main centres of Darwin and Alice Springs, and among the Aboriginal population, there was little information to permit assessment of need.

4.7.1
LIST OF EARLY INTERVENTION PROGRAMS (Northern Territory)

Government Departments

Education Department

- Early Intervention Program for Hearing Impaired, Stuart Park School
- Early Intervention Program for Visually Impaired, Tiwi Preschool

Voluntary/Private Parent-Support Group Program

- Early Intervention Service, The Spastic Centre
- Specialist Advisory Service, Down's Syndrome Association of the Northern Territory, Casuarina

Other Agencies or Groups Associated with Early Intervention Programs

- National Acoustics Laboratory
- Darwin and Alice Springs Hospitals - support services to children and families, including medical and paramedical services
- Community Health Services - Child Development Clinic, Alice Springs
- Toy Library Service, Darwin
- Education Department Special Services
- Down's Syndrome Association
- National Hyperactivity Top End Resource Centre
- Spastic Centre
- ANSUA
- Group for parents of visually-impaired children

4.8

EARLY INTERVENTION IN THE AUSTRALIAN CAPITAL TERRITORY

The Therapy Centre administered by the Capital Territory Health Commission was the hub of service provision for very young children with disabilities in the Australian Capital Territory. The Therapy Centre at Griffith was established at the beginning of 1974 to provide a comprehensive service for all handicapped children under three years of age. Not only individual therapy programs but also a playgroup, directed by a pre-school teacher supplied by the Schools Commission or the Australian Capital Territory Schools Authority, were provided for children from 18 months to three years of age. The Pre-school Section of the Australian Capital Territory Schools Authority also co-operated with the Health Authority's Therapy Centre by providing itinerant teachers who offered home-visiting services to visually-impaired children (6 children under five years of age in 1979) and home-visiting from birth for hearing-impaired children (16 children under six years of age in 1979). There was no other early intervention service (according to the definitions used for this research) for the 0 to 3 year age group.

It is important to note the way a child entered the system. Each child had to be referred by a pediatrician. Thus a parent concerned about the child might have gone through the following process before assessment and programming could be accomplished:

> Visit to general practitioner → referral by general practitioner to pediatrician → referral by pediatrician to Therapy Centre.

After referral to the Therapy Centre, there was a parent interview by a social worker at the centre or in the home, a physiotherapy assessment, a medical officer's interview with the family and, if the child's needs warranted it, an occupational therapy assessment. The program centred on physiotherapy. Unlike the services of the Division for the Intellectually Handicapped in Western Australia, where psychologists provided the major input, the Australian Capital Territory Therapy Centre services emphasized physiotherapy. In fact, the Australian Capital Territory was the only state in which physiotherapists had such a dominant role in early intervention programs. Of the seventeen therapists at the Centre in 1979, nine were physiotherapists. There were no psychologists. A speech therapist was at one time a member of the team and great concern was expressed by staff and parents about the inability of the Therapy Centre to hire another speech therapist.

Links between services were partly provided by the medical officer at the Therapy Centre, who served as a liaison between the Centre and the six pediatricians who were referral sources. The fact that all therapists worked only part of each week at the Centre and spent the rest of their time with older children at various schools meant that there was continuity of programming for the children and sharing of skills between the Education Department and Therapy Centre staff.

At three years of age, a child was considered by an assessment panel that determined whether he needed continued help from the Therapy Centre or whether he should be referred to an Education Department service. The Australian Capital Territory Schools Authority was primarily responsible for intervention activities for children after the age of three years. Children with predominantly physical handicaps were referred to Hartley Street Pre-school. Those with predominantly intellectual handicaps were referred to Malkara, Koomarri* or Cranleigh Pre-schools. The pre-schools were known as "Pre-schools for Special Purposes" but also served children without disabilities. These pre-schools were under the authority of the Australian Capital Territory Schools Authority.

Placements in Pre-school Assessment Groups administered by the Australian Capital Territory Schools Authority were available for children whose handicaps were not primarily physical or intellectual, such as those with hearing or visual impairments. These Pre-school Assessment Groups provided integrated situations as some non-handicapped children were also included in the groups. The groups might change in location depending on needs, but at the time of the study they were located at Bannister Gardens in Griffith, Throsby Crescent in Griffith, Macquarie, Haig Park and Canberra Pre-school Centres. Serving several purposes, the Pre-school Assessment Groups offered opportunities for children already enrolled in programs at Pre-schools for Special Purposes to be integrated in a local pre-school program, or offered a pre-school education opportunity to children who had been served until the age of three by the Therapy Centre, but for whom it was too early to make a decision about placement in a regular or special school. Despite the nomenclature, Pre-school Assessment Groups were not designed for assessment but for intervention. The 'assessment' label indicated that many of the children had special needs that were not as clearly definable as the needs of those in the Pre-schools for Special Purposes.

4.8.1

Programs Related to Early Intervention or Broadly Characterized as Intervention

Integration of young handicapped children in regular pre-schools has not been treated in this research study as early intervention as such, and there is ample support in the literature for this. However, integration is broadly an intervention activity. In Canberra, as in some of the states, one or two children with special needs could be accommodated in regular pre-school units or classes. Approximately 168 children were placed in normal pre-schools in Canberra at the time of our study and most pre-school teachers had at least one child with special needs in the classroom.

The Australian Capital Territory Schools Authority accorded children with special needs of a slight or mild nature a high priority on waiting lists for neighbourhood pre-schools. Not only the child's needs but urgent family needs (physical, mental or emotional) were considered. The Pre-school Section also provided family support by offering 'Referred Programs' in local pre-schools, located recently at Hopetown Circuit Deakin, Lyons, Reid and Schullin pre-schools. Siblings of children attending special schools or the Therapy Centre could attend two of the four weekly sessions of these regular pre-school programs. Children with special needs who were aged three to three and a half years, but who might benefit from placement with younger children, were eligible for this program. Although these services, like integration services, were available and were broadly defined as early intervention, these 'Referred Programs' were not included in our detailed data analysis.

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* Although available for use Koomarri had not been needed recently and thus was not included in our questionnaire study.

A number of agencies, programs, and government department services were available to the families of handicapped children and to the larger community. Although these services have not been classified as early intervention for the purposes of our wider study, conducted through questionnaires, they are important and should be mentioned.

An important contribution to the development of young handicapped children was made by the Noah's Ark Centre, which offered a selection of toys and equipment, playgroup opportunities, and advice on the use of toys. The mobile unit extended services to the handicapped where early intervention programs were not available and where parents would otherwise have to travel very long distances to obtain assistance. The Assessment Centre of Intellectual Handicap Services provided counselling and guidance for handicapped people and their families after referral by a doctor. The Australian Capital Territory Schools Authority Education Clinic played a useful intervention role by giving assessment and therapy for children with handicaps or learning difficulties. An advantage to parents of this service was that referral was not necessary.

Both government and non-government residentials could be called upon. Health Service Hostels, located at Bruce, Chapman and Melba and other hostels (Hartley House and Queen Elizabeth II Coronation Home) were available and Birralee offered parent support by making available short-term accommodation. The Health Authority's National Acoustic Laboratory was a resource, as was the Blindness Resource centre associated with the Royal Guide Dogs for the Blind.

Generic services offered to the entire community can be a significant source of help to the families of handicapped children. For example, the Australian Capital Territory Health Authority's child and family guidance clinics and community health centres, hospitals,* libraries, family day care, and the local government occasional care centres, Domiciliary Support Services (Emergency Housekeeping and Home Help Service, the District Nursing Service) could be utilized by families with handicapped children. Associations, both generic (Australian Pre-school Association, Canberra Branch, Australian Capital Territory Association for Early Childhood Development) and specialized (Australian Capital Territory Society for Physically Handicapped Children, Autistic Children's Association of Australian Capital Territory, SPELD, National Hyperactivity Association of Australian Capital Territory, and South New South Wales, Australian Association for the Mentally Retarded) existed as resources as well.

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* The Woden Valley Hospital Rehabilitation Unit, for example, provided paramedical services through the Hartley Street School for Special Purposes.

In summary, the central role of the Australian Capital Territory Health Commission in the provision of early intervention services was the dominant feature of the overview of programs for young handicapped children in the Australian Capital Territory. This involvement produced a heavy emphasis on the delivery of therapy services. Educational service provision for very young handicapped children seemed less well developed than in the states.

4.8.2
LIST OF EARLY INTERVENTION PROGRAMS (Australian Capital Territory)

Government Departments

Australian Capital Territory Health Commission
(with co-operation from the Schools Authority)

- Therapy Centre (Throsby Crescent, Griffith and David Street, O'Connor)

Australian Capital Territory Schools Authority

- Schools for Special Purposes
- Malkara (predominantly intellectual disabilites)
- Cranleigh (predominantly intellectual disabilities)
- Hartley Street (predominantly physical disabilities)
- Pre-school Assessment Groups
    - Bannister Gardens, Griffith
    - Throsby Crescent Pre-school, Griffith
    - Macquarie
    - Haig Park (to be moved to another location)
    - Canberra Pre-school centre (to be moved to another location)

Tertiary, Private and Other

- No early intervention program sponsored by or associated with a tertiary institution was currently in operation. However, a program for training parents as language therapists existed until 1978 at the Canberra College of Advanced Education.*

  A number of Australian Capital Territory and New South Wales teritary institutions arranged for students to be trained in association with existing early intervention services: for example, Riverina (Wagga Wagga), Goulburn (New South Wales), and the Canberra College of Advanced Education as well as the Child Care Department of the Canberra College of TAFE.

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* See Rees (1978) for a discussion of the Canberra College of Advanced Education program.

The services of the Australian Society for Brain Injured Children were available to Canberra residents through the Melbourne office, but this program is discussed in relation to the state of Victoria.

Voluntary Agencies

- No voluntary association provided an early intervention program per se, although the Australian Capital Territory Society for the Physically Handicapped provided supplementary funds to the Hartley Street Pre-school, and a group of parents of hearing-impaired children contributed to defray costs of running the Australian Capital Territory Schools Authority Assessment Pre-schools.

4.9
CONCLUDING SUMMARY

The patterns of services described in the preceding overviews reveal differences both between states and within states. This seems to have been the inevitable result of the evolution of program initiatives in a sporadic sequence.

The direction of this evolution has been determined by the presence of identified needs and the network of agencies available to provide services to meet these needs. Such developments have occurred well in advance of the formulation of strategies to regulate the development of services and policies to co-ordinate their delivery. There is a clear need for governments, at both state and federal levels, to make the formulation of such policies an urgent priority.

The establishment of inter-departmental committees on early intervention in several states is a promising sign that such policies will be forthcoming in the future. Rationalization of overlapping services and better co-ordination to fill gaps in services delivery, particularly in urban centres, is a process already under way in some states. All states and territories face problems in attempting to provide a uniform availability of early intervention throughout their many regions. This is particularly the case in rural settings where distance and reduced availability of professional resources combine to create a major impediment to the delivery of early intervention services.

Nationally, the major difficulty in framing a coherent policy for early intervention seems to reside in the problem of accommodating the very different patterns of administrative responsibility for early intervention by government and non-government agencies. It is to be hoped that the present research will facilitate the process of accommodation. Before this can happen, a clear picture of the national scene in early intervention will be an essential prerequisite. The following chapter provides such a map, derived from the data provided by the sample of programs either visited or surveyed by questionnaire.

Toy libraries have not been described systematically in this chapter, except where they have played a particularly integral role in the evolution of the particular pattern of early intervention in a state or territory. A more comprehensive treatment of the place of toy libraries in the Australian context is provided in Chapter 8.

CHAPTER 5

EARLY INTERVENTION PROGRAMS IN AUSTRALIA: MAJOR CHARACTERISTICS

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*In the early part of this chapter important characteristics of early intervention programs are discussed primarily on the basis of information gathered on site visits, in workshops, and by correspondence.** *Several broad issues are addressed in a non-quantitative fashion: the approaches taken to early intervention in terms of particular models, the sponsorship of the programs, their orientation, their focus in terms of their clientele, the patterns of staffing and staff relationships among staff, and the strategies exemplified in the programs. The second part of the chapter presents data obtained from questionnaires supplied by early intervention programs. Information on the length of time Australian programs have been established, the numbers and ages of children served, sources of funding, types of professionals providing services, methods of assessment, and perceived strengths of the programs are provided in this section. The perspectives of parents are reported in Chapter 6.*

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* *Appendix I is a site visit interveiw/observation guide.*

Appendix J gives tables of basic information on programs in this study.

5.1
APPROACHES TO EARLY INTERVENTION

Services to handicapped people can broadly be categorized as embodying a medical, educational, social welfare or recreational emphasis. All of these orientations have a legitimate place in early intervention, although the social welfare and recreational approaches tend to be more relevant to ancillary services than to early intervention itself. All four approaches, when applied to young children, have certain similarities, the main differences being reflected in the kinds of personnel employed to implement the programs and in associated program emphases.

The classic medical or therapeutic model focuses on five major concerns: prevention, diagnosis, treatment, care and habilitation. All of these may be related to early intervention even though they are not in themselves developmental programs. Thus prevention, as in genetic counselling, may result in the conception or birth of a child free of a handicapping condition which would otherwise have required intervention; where prevention has not been possible, diagnosis is necessary before appropriate intervention can be planned and attempted; treatment may change a handicapped person's capacities, for example, surgery or physiotherapy for a cerebral palsied child can change his functioning and affect the kind of intervention that is required and provided; high quality care is needed to provide an appropriate environment for learning and accelerated development; finally, without proper attention to his physical needs, the handicapped person's development will be at risk. Of the five major concerns of the medical or therapeutic model, however, habilitation most closely approximates early intervention in concept. Habilitation implies amelioration of physical disabilities in a systematic series of activities especially designed to enhance development.

Although most habilitation programs seemed to be focused on physical disabilities, they were developed for other disabilities. Emphasis tended to be placed on motor skills (gross and fine) and self-help or self-care skills such as feeding and toileting. Most commonly medical and paramedical staff and therapists were involved in habilitation: nurses, physiotherapists and occupational therapists. However, developmental and educative aspects of habilitation have led to a conceptual rapprochement between the medical and educational models, although philosophically and pragmatically the distinction may still be maintained. For example, skill development programs operated by nurses at the Bambi Nursing Home (associated with the Intellectually and Physically Handicapped Children's Society of New South Wales) had characteristics of early intervention although the staff considered the program to be habilitation. In some medical settings the distinction between habilitation and intervention was withdrawn, and full recognition given to the indivisibility of the various types of services for young handicapped children. For example, in the privately operated Allowah Babies Hospital in Sydney, which provided nursing care primarily for handicapped children whose parents had chosen the alternative of institutionalization, a teacher with specialist training was hired to carry out an early intervention program for the institutionalized babies and young children. Laurel House also provided an intervention program with an educational orientation in a medical setting. These two examples illustrate that intervention within an educational model can exist in a medical setting, and that the relationship between habilitation and educational intervention, between a medical and an educational model, can be a close one.

In some other medical settings where care was understood and provided as part of a medical model, the distinction between a medical and educational model was difficult to maintain. For example, Mental Deficiency Nurses in New South Wales made home visits in which they provided care and treatment in the traditional sense; however, they could also provide educational intervention by advising the mother on ways of helping the child develop. At the Royal Children's Hospital in Melbourne one of the programs in operation, while not necessarily viewed by the hospital staff as an early intervention program, nevertheless bore some characteristics of such programs in that it was a long term program to foster development. It is interesting to note, too, that the process of diagnosis may have developmental implications. For example, in the Barwon Region of the Victorian Health Department the "ongoing assessment" which was provided not only resulted in observation and assessment but it might also affect the development of the child over a period of time.

The classic educational model of services to young handicapped children has two major aspects: assessment and education. While this model frequently focused on cognitive areas of development and, in particular, language development, a comprehensive approach was typical, with some attention paid also to motor skills, sensory stimulation, self-concept, and social skills.

Some programs that might be called "early intervention" were classified as "ongoing assessment". For example, an education department which did not officially provide intervention might incidentally do so as part of the process of determining appropriate later placement in a pre-school or primary school. An example of such an assessment program occurred in a playgroup provided by the Metropolitan West Regional Office of the New South Wales Department of Education. With parents accompanying them to learn how better to assist their children's development, the children were assessed, but were necessarily also, in the process, learning language and social skills.

Educational intervention, the fostering of a developmental prerequisites to later learning and development, occurred in a number of settings: playgroups, pre-schools, clinics and homes. Although in some programs the focus was on work with an individual child and parent(s), most intervention programs were directed to groups of children, with or without their parents present. Existing home-based services tended to use educational materials and resources to encourage parents to become teachers of their children. Sometimes the home-based programs combined aspects of the medical and educational models or used personnel who had qualifications other than diplomas of teaching. For example, the Division for the Intellectually Handicapped in Western Australia employed "social trainers" as home-visitors. The social trainers, who were members of a multidisciplinary team that did not include teachers, underwent a twelve month training period conducted jointly by the Division for the Intellectually Handicapped and the Social Studies Department of Perth Technical College. The Intellectually Retarded Services of South Australia used "Activity Advisers" as home visitors; at the time of our site visit, the qualifications of the Activity Advisers included a Child Care and Development Certificate (University of Adelaide and South Australian Council of Social Service), a British Home Office Residential Child Care Certificate, and a Mental Deficiency Nurse's qualifications. In this case the supervisor of the Activity Advisers had a teaching diploma and a degree of Bachelor of Special Education.

The educational program was frequently accomplished through play activities, usually highly structured ones in which children participated in games with specifically defined educational goals. Most playgroups we observed followed a typical pre-school model in this respect. However, there have been exceptions. One playgroup type of program that planned for spontaneous play was Multicap's program in Toowoomba, Queensland, which included very few children of early intervention age. A child was given access to a number of toys. As he began to respond to a particular toy, the leader fostered that interest and encouraged him to play with the toy. Although group activities required structure, these were complemented by the spontaneous play period. Spontaneous play is a rich area for learning, but it is not easy to provide high quality opportunities without adequate resources, including personnel sufficient to permit undivided individual attention to a child during the spontaneous play period, a wide variety of toys, and plans to reinforce appropriate relationships in interactional play. In programs where parents were encouraged to teach their children, mothers sometimes were given advice on how to provide a stimulating environment for play and how to reinforce play activity.

Most spontaneous play occurred in programs other than early intervention and could be characterized as "supervised" rather than "planned". Spontaneous play for very young handicapped children was generally to be found in activities offered by recreational services. The recreational model of services, when applied to children of early intervention age, was exemplified by playgroups that were unstructured and that had as their major purpose child-minding, parent relief, entertainment or socialization opportunities for the children. Structured play activities within the recreational model included horse-back riding, swimming and other specific skill activities as well as comprehensive skill activities such as those pursued at holiday camps. While providing a wide range of activities, holiday camps were usually provided for older children, and when available for younger children, were short-term and thus are not considered "early intervention" for the purposes of this study.

The social welfare model is perhaps the original source of the focus on families that is now part of the early intervention scene. This model, implemented by social workers and psychologists primarily, has tended to operate on the premise that what is good for the family will benefit the child. A hypothetical example of this general model might be a program for single mothers of handicapped children that focuses on the mothers' needs as well as the children's - for example, needs for job skills, emotional support, educational opportunities, and child-care relief. The Family Training Unit of the Intellectually Retarded Services in South Australia was an example of a social welfare model; the young handicapped children were not given direct early intervention services, but rather their parents were offered courses to help them manage and direct the growth of their children. The only social welfare program of early intervention studied intensively in our research was the New South Wales Early Infant Stimulation Program of the Handicapped Persons' Bureau, Department of Youth and Community Services. Co-ordinators implementing this program tried to help parents of handicapped children take full advantage of various services available, and to make choices among programs about which the co-ordinators could inform them. The co-ordinators also made efforts to foster co-operation among agencies serving the handicapped in a given area. Without providing a direct hands-on service, the program expressed the principle that the family is the decision maker, needing not prescriptive advice, but clear descriptions of available options. The program reflected some of the notions of advocacy that are coming to the fore in services to the handicapped, including the idea that the family needs a neutral information source as well as program providers with commitments to given philosophies of education or methods of intervention. Increasing concern for family choice has also characterized other models of service to the handicapped.

In summary, of the various models of services to the handicapped, the medical and educational models tended to be those most commonly adopted in early intervention programs. In early intervention programs observed in Australia, differentiation between medical and educational models was often clearcut, with some programs employing only personnel with a medical orientation and placing their emphasis on habilitation, and others employing only teachers and stressing education. Yet the staff of most programs acknowledged the value of both models, and would accord importance to a transdisciplinary approach involving both therapy and education. It seems that frequently the styles of intervention activities of therapeutic and educational staff overlapped markedly, so that a co-operative and unified effort is indeed possible.

Although programs exemplifying recreational and social welfare models were not the focus of this study, they have contributed a great deal to the concept of early intervention, and place emphasis on ancillary services for which parents are expressing great need. Such ancillary services often had important adjuncts or provided the necessary environments for early intervention, and demonstrated the inter-relatedness of the needs of young handicapped children and their families; these children and their families function as a fundamental unit for service delivery.

Although there are differences in the models that may result in conflict between proponents of the various models, those differences seemed often not to be closely related to deeply held convictions about what is appropriate intervention. Most interveners seemed to consider ideal the contribution of various kinds of professionals in a team setting. The reason such an ideal was not more frequently encountered had more to do with administrative idiosyncrasies of departments or agencies than with a belief that the help of particular professionals was not needed. For example, health departments may not be able to hire teachers and education departments may not be able to hire therapists; yet early intervention program staff in many health-related settings seemed to acknowledge the importance of teaching input, and those in educational settings acknowledged the need for therapists.

Where conflict was most apparent was not in relation to early intervention programs themselves, but rather in relation to services which did not see the need for intervention or which did not offer such programs. At the extreme in a health setting, this was demonstrated by those who believed medical care alone, in the form of prevention, diagnosis, and remediation was sufficient to serve the needs of a family with a handicapped child. In such a case it was considered that the education of the child would appropriately commence at age 5 or 6 years and assistance to the family as an educative agent in itself was not considered necessary. At the extreme in an educational setting, the educator felt that nursing, therapy or other staff without formal teaching qualifications could not be centrally involved in educative activities. Narrow professionalism and administrative territoriality existed and interfered with the development of optimal services for young handicapped children. This issue is explored further in Chapter 9.

5.2
SPONSORSHIP

A major determinant of the nature and characteristics of any program was its sponsorship and hence its setting.

If, for example, it was a Health Department or Health Commission program the setting was likely to be a hospital, residential institution or hostel, an assessment centre or possibly one of a number of generic services for the community such as baby clinics or community health centres. Within a hospital, the departments most likely to provide an early intervention service included psychiatry, occupational therapy, physiotherapy and pediatrics. The terminology used was generally medical; that is, children who were served within the institution were in-patients, those who visited a clinic at the hospital out-patients. People involved in a hospital service were nurses, physiotherapists, occupational therapists, speech pathologists, social workers. Residential institutions such as hostels for the intellectually handicapped tended to have programs that were carried out by nurses or residential care staff, often involving input from psychologists, and because of the severity of handicap of children in residential institutions, programs had typically been limited to a focus on self-care skills such as feeding, toileting, management, and other programs that had relatively limited goals. However, some residential institutions had recently developed toy libraries to ensure that children had appropriate playthings and there was increasing awareness of the value of play and of fostering play behaviour in children.

Assessment and therapy services to handicapped children varied markedly from state to state, thus rendering difficult any generalizations about health services in assessment and therapy settings. In addition, assessment facilities of health departments, particularly in relation to disability, appeared to be undergoing change; assessment centres in some areas seemed to emphasize assessment activities while in others the therapy or intervention following assessment was also seen to be of vital importance.

Education departments were typically involved in early intervention through the provision of special pre-schools attached to special schools or of regular pre-schools into which handicapped children might be integrated and provided with visiting teacher support. Home based programs tended to be provided for young hearing-impaired children; at times support was provided to voluntary organizations who offered such a service. Education Departments employed, as might be assumed, mostly teachers but in some cases they also utilized the services of psychologists and speech therapists; other professionals such as physiotherapists, occupational therapists and social workers tended not to be included in departmental staff.

Until relatively recent years, education departments were not involved in the offering of programs to children below statutory school age except in cases of hearing-impairment and sometimes visual-impairment; such involvement is now substantial in all states and territories except New South Wales and Victoria. Acceptance of responsibility for younger age groups has undoubtedly facilitated their provision of intervention programs for handicapped children of pre-school age. There is a growing belief that these departments should be responsible for the education of all children with a handicap from birth or from first identification of the handicap; such a recommendation has been made, for example, by the Council of Special Education in Western Australia and by the Advisory Council for Special Education in Queensland. In the preceding chapter we have discussed programs offered by education departments to very young children.* Typically, state education department services have provided through guidance/school counselling/special education branches and/or through pre-school divisions.

Programs associated with tertiary institutions were studied. Each tended to depend on the particular person whose interest in early intervention resulted in the establishment of the program and thus there was marked variability among them. The programs were not usually sponsored by the institution although institutional facilities might be used. All of the early intervention programs associated with tertiary institutions which we noted were connected with departments of education or special education; there were none associated, for example, with departments of occupational therapy. These programs tended to be somewhat less eclectic than those offered by other agencies, since they drew heavily on the particular expertise and philosophical orientation of the founder. Assuming Wolfenberger's premise that devalued persons such as handicapped children benefit by association with prestigious institutions or organizations, the location of programs on the sites of tertiary institutions would seem to be a strength. However, as we discuss in Chapter 9, the role of tertiary institutions in the provision of such services needs clarification.

Voluntary associations were important sponsors and settings of early intervention programs. There were two major types so involved. The first, which often evolved with time into the second, was a voluntary organization instituted by parents of children with a particular disability (e.g. Down's Syndrome Association, Northern Territory) or developed by a community group in order to act as a pressure group for change or the establishment of a program. The second group included those organized on a state or national level, usually in relation to a particular type of disability such as associations for the blind, for the deaf and hearing-impaired, for the physically handicapped, for the intellectually handicapped.

The small voluntary associations, made up of parents of handicapped children and others interested in disability, have played an important role in initiating early intervention programs. Playgroups and day care centres that were broadly defined as early intervention were in many cases begun by mothers of handicapped children who recognized the need and co-operated to seek funds to institute and support the service. These groups, however, generally had very few resources and frequently could employ only one person to provide the intervention service. In some cases, of course, support services from outside the group were available as a supplement. It is interesting that several of these voluntary community groups had developed to establish an alternative to services already provided by well-established voluntary associations; sometimes the alternative was sought as a way of avoiding what was perceived as a non-normalizing service. The proliferation of small community groups, frequently made up of parents seeking services, suggests that there needed to be more avenues for parents to use in seeking appropriate services. Very frequently the resources in the community were available but tapping them was not an easy task. At the same time, many voluntary associations were seeking to expand their clientele, particularly at very early ages, recognizing that developmental delay might be due to a variety of handicaps. Voluntary associations had considerable potential for flexibility in the staffing of programs, since they did not have some of the rigid employment regulations that tend to characterize government departments.

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* A separate report by the Schonell Education Research Centre on the pilot early intervention projects of the Queensland Education Department was referenced on p.50 (Hayes *et al.* 1981).

The increasing emphasis on pre-school education in the general community, and the simultaneous interest of education departments in pre-school children, means that in many instances pre-school services offered by voluntary associations were almost entirely subsidized by government. In some areas this has had the effect of creating greater interest in earlier intervention, that is from birth up to the age of three years, as voluntary associations have reassessed the needs of the community and their own resources. For example, when in South Australia the Education Department made provision for the education of children aged three and over, the Intellectually Retarded Services of the Health Department began to offer a home-visiting program that developed into an activity advisers program with playgroups for children from birth onward.

5.3
PROGRAM ORIENTATION

The vast majority of programs observed througout the study were established for the purpose of providing service to families and children. There were, however, some programs that had been intended primarily for research purposes, and others for the training of professional staff to work with children in early intervention programs or children with particular disabilities. Because of the very urgency of the needs of the people who were being served by research or training programs however, programs which had an original purpose other than service, in fact came to emphasize that aspect: for example, the Preston Institute program (EPIC) in Victoria was considered by some as an essential program, although its original purpose was not to meet the needs of people in that area so much as to test the effectiveness of certain types of programs.

Program related research was frequently intended to test new ideas, experimenting to discover if they were effective or to compare alternative methods to determine which seemed most appropriate in a particular setting.

It appeared that some of the projects designed to test such research questions had developed into documentation and/or self-evaluation projects partly because the perceived need had been so great that the program became a service rather than a research project. Such a change in focus has implications however for the future of the program. Where programs have maintained their research focus, at the conclusion of the research there may well be no way of assuring the continuity of that program. Presently there is no way for the translation of a basic research project into a service. The Newcastle College of Advanced Education Language Development Program, which set out to train parents as therapists, is an example of a research project that did in fact end when the original purpose had been achieved. It could be argued that this is a natural progression from basic research to service and, subsequently, parent lobbying for replacement of that service, if in fact a need has been shown to exist.

Very few programs had been established solely for training purposes. In most cases training took place in co-operation between a college of advanced education or university and an early intervention program; for example there was co-operation in Victoria between the Royal Victorian Institute for the Blind and Burwood State College and in South Australia between the Autistic Children's Association and the Adelaide College of the Arts and Education at Underdale.

5.4
CLIENT FOCUS

As well as being able to differentiate the programs visited in terms of their philosophical orientations, it was also possible to differentiate them by studying the clientele upon whom the program focused. Although the staff of virtually all the programs mentioned the importance of the total family, programs differed enormously in their approach to providing a service which may ultimately benefit the total family. It is, therefore, possible to describe the focus of programs by grouping them upon the basis of the recipients who receive most of the program staff's time. Some programs such as that at Newcastle College of Advanced Education, the Department of Health's Central Assessment Clinic in Brisbane, and the Department of Health's Division for the Intellectually Handicapped (Irrabeena) in Perth provided comprehensive services for families and focus upon each of the following clientele groups but most programs tended to focus upon a specific clientele group. These three groups can be broadly described as the individual child, groups of children and children and their families.

5.4.1
The Individual Child

Programs which focused upon individual children tended to be those programs which were centre based; some, however, were home based with program staff working directly with the child in his home. While complementary services have sometimes been provided, in many cases the focus solely upon the individual child was a result of limited resources, an attempt to make the best use of the skills of the program staff and/or a response to a commitment to avoid increasing the workload of a family, one of whose members had a handicap. Some programs, such as the Macquarie Project, considered this latter reason as being an important aspect of the rationale of their program and, in addition, saw this type of program as reflective, from the family's perspective, of the principles of normalization. Referrals from the program were made to other services available in the community for the families of the children in the project's program. The centre based component of the program focussed upon the individual child. This focus was also typical of the centre based components of the program at Newcastle College of Advanced Education, the emphasis being upon the individual child and wherever possible providing for one-to-one instruction while at the same time allowing opportunity for group interaction and group forms of instruction. The Marsden Hospital program also provided one-to-one instruction as well as group programs, but involved less frequent interaction with the children than was the case with the two previously mentioned programs; since this program was often a supplement to other forms of service, the focus of the program could be child oriented, with the family's needs likely to be met via other placements and services. Yet other programs, while attended by groups of children, provided a focus on the individual child in their implementation of a philosophy of individual attention and their recognition of the needs/characteristics of the children.

While playgroups and kindergartens were available to and helpful in preparing children for more formal learning, it was apparent that some children with problems such as limited mobility or distractibility did not respond well to large groups which could be confusing and too unstructured.

Thus for a variety of reasons, several programs could be found in which the individual child was the focus of interest and activity.

5.4.2
Groups of Children

Focus upon groups of children was usually the result either of limited resources or, by contrast, a response to the principles of normalization whereby children with mild handicaps were integrated into regular settings. Playgroups such as those organized by the Subnormal Children's Welfare Association in New South Wales provided an example of programs offering a service to handicapped pre-school children. The Association expressed a desire to do more individual programing but, in their circumstances, a focus upon groups of children allowed the best use of existing resources and fulfilled a community need for the children concerned.

5.4.3
Children and Their Families

The importance of seeing the child as part of the family unit stems from the recognition that the entire family is affected by the child with a disability and that the child is in turn affected by the family. Sibling rivalry, marital tensions and the problems that are generally described as logistical can create a poor environment for the development of the child with a disability and all other members of the family.

Regardless of the focus, type or intensity of the programs visited by our teams, parental involvement in programs was mentioned by all program staff as being important.

However, the type of involvement actually occurring varied significantly among the programs visited. Firstly, whether a program was predominantly centre or home-based influenced the amount of contact with parents. Many centre-based programs such as Kate Cocks Day Care Centre in Adelaide, Shannon Park Centre at Geelong and school-based programs such as those at the Malkara School in Canberra and the Autistic Children's Centre in Brisbane arranged home visits if a situation required such a visit, but most parental involvement took place at the centre. Contact was also maintained with parents in many programs by maximizing the opportunities created by incidental contact, such as when parents transported children to the centre or attended the centre as part of a roster system. This incidental interaction between parents and staff in relation to transport arrangements was mentioned by some program staff as one of the advantages of not providing transport for all children.

Whether programs made more specifically planned provisions for parents depended very much upon other local community provisions and whether the program was part of a larger organization. For instance, in South Australia, a Family Training Unit which was part of Intellectually Retarded Services provided a service for families which the early intervention programs administered by the Services and by other South Australian early intervention programs could utilize. The Queensland Department of Health's Family Education Unit in Brisbane also provided a similar type of service specifically for parents involved in Central Assessment Clinic programs, but a service was also provided for other parents of handicapped children. Not all communities had such a service. In response to overloaded services, some programs provided their own family training programs.

The Monnington Centre and the Royal Victorian Institute for the Blind in Victoria are two examples of programs which placed a considerable emphasis upon meeting the needs of the whole family. At the latter, a three hour afternoon program for parents of home-visited children was held weekly. For one hour of this period, staff were not present; parents then had a two hour session with staff, covering a range of topics, some selected by the parents and some suggested by staff. The parents of children attending the Institute's centre-based program visited the centre one hour a week for family support and skill training and for the reporting of information about the child's progress. The approach taken to family involvement at the Monnington Centre is best described by Hewitt (1977). Emphasis was placed upon planning for a variety of forms of parental involvement to allow for changing family needs as the child moved from the early intervention program to other programs in the Centre.

The EPIC program at Preston, Victoria also arranged its own family training programs. Two postgraduate students and the director of the program were primarily responsible for these. In programs emphasizing specific skill development such as EPIC (Victoria), Children's Centre, Macquarie Project (New South Wales) and Irrabeena (Western Australia) the mother tended to be seen as the prime care giver who had most contact with a child and hence the person whose skills could have the most effect on the child. Emphasis was therefore placed upon developing the parents' (in most cases the mothers') skills and hence reducing parent anxiety while at the same time improving the child's skill development. By contrast, in centre-based programs that interacted primarily with the child rather than the family, the provision of such a program was often seen as being in the family's best interests, facilitating a mother's attempt to lead as 'normal' a life as possible and to have freedom from total responsibility for the child all the day. This approach, as well as heavy work load commitments, often resulted in concentration upon the child at the centre and made a minimum of demands upon the parents. Whereas some programs emphasized crisis counselling and support, other programs acknowledged the need for support but responded to this need by helping the parents to develop skills so that they could actively help the children's development and overcome their own feelings of helplessness.

Most of the focus on families was aimed at the parents but some programs gave attention to the handicapped child's siblings. Sometimes they were helped indirectly as programs emphasized the skill development of parents or provided support through counselling to siblings. However, some programs, such as the Royal Victorian Institute for the Blind and Shannon Park in Victoria, included siblings in the centre-based components of their programs. So too did the Subnormal Children's Welfare Association playgroups which offered a service to approximately 200 children in the metropolitan area including about 30 siblings as well as some children who were only mildly delayed. Including the siblings in the program was seen as providing normalizing experiences for the handicapped children in the program and at the same time providing an additional service for the family of the handicapped child.

The Australian Capital Territory's School's Authority Pre-school Section provided family support by offering 'referred programs' in local pre-schools; siblings of children attending special educational placements or the Therapy Centre might attend two of the four weekly sessions.

The Department of Health's Family Education Unit in Brisbane provided a Brothers and Sisters Group program; this program was organized for the brothers and sisters of intellectually handicapped children and the group addressed issues related to questions and reactions from friends about having a handicapped brother or sister. The Southern Tablelands Child Development Unit also organized a siblings group which operated once a week for six weeks, and other programs offered services to siblings as well.

Although all programs acknowledged the need for family involvement, the philosophical orientation of the program, the base of the program and the resources of the program greatly influenced the relative emphasis which programs placed upon the individual child and upon the family.

5.5
PATTERNS OF STAFFING AND STAFF RELATIONSHIPS

There were four basic patterns of staffing that were observed in early intervention programs. First was the offering of service by an individual specialist. In many early intervention programs there was only one major provider of the service, a teacher or a therapist for example. This individual, perhaps, had some very limited support from other staff. Some programs such as the University of Western Australia program had several specialists, each of whom in essence worked as an individual to provide the service to the particular children who seemed most to need his/her particular skills. Thus an occupational therapist might work with some children, a physiotherapist with others, possibly a teacher with still others. In this type of service some children might see more than one therapist but each offered an independent program. There might have been some communication between the specialists but it really was not a sharing of skills, and since many of the children did not participate in more than one of these independent programs little need was seen for consultation.

The remaining relationship patterns tended to be an expression of a team approach. However, there were various kinds of such approaches. In some instances, a team consisted of many therapists or other professionals who provided service to the same people. In this sense the team approach did not need to involve particularly close relationships between members who did, however, view themselves as providing a similar service and who from time to time had occasion to discuss some of the same children. Reference to a 'team' in a program thus did not necessarily provide detailed information about the actual relationships between the team members.

One kind of relationship might be described as that which existed between complementary specialists or members of an interdisciplinary team. This type of team involved various kinds of professionals who viewed their activities as being related but each individual therapist, teacher or other professional provided his or her own service using the special skills that had been learned. Although there was discussion and communication between various specialists about the children, each provided a unique service and looked upon himself or herself as providing expertise in that given area, doing something which no one else on the team could do. This was sometimes reflected administratively in separate departments, for example an occupational therapy department, a physiotherapy department. In these instances the individual therapists worked with their peers in other areas of their work, but for the early intervention program had a representative who worked with very young children and who had informal contacts with specialists from other fields, reporting, however, to the home department. For example, although there was very close contact between the physiotherapy department and the activity advisers' service of the Intellectually Retarded Services of South Australia, nevertheless the physiotherapists were under the administration of a physiotherapy department. Departmental barriers were beginning to break down. Thus even when a service reflected the historical pattern of specialist departments, the individuals in those departments, for example the physiotherapists and occupational therapists, looked on themselves as being members of an early intervention team. It is difficult to classify particular programs because in some cases there was a transition taking place between an old system where specialists had their individual departments and a new system where several departments combined their efforts to bring their particular skills to bear in an early intervention program.

The transdisciplinary team was still another expression of teamwork. The Northern Region team of Intellectually Retarded Services in South Australia is a good example of this type of team. It incorporated people from a variety of backgrounds with different professional skills; for example there were a psychologist, an activity adviser who went into the homes, a physiotherapist and other professional staff. The concept of the transdisciplinary team assumes that no particular individual is indispensable but that all can help the others to achieve their ends, so that there is a kind of core of skills which all share. The activity adviser, whose job was to provide training and advice to the parent and to demonstrate some of the activities which would be useful in assisting the child to develop, might have learnt from a physiotherapist particular ways of encouraging the child to develop certain motor skills, particularly in cases where a specific physical disability created difficulties for the child. Many of these early intervention programs aspired to the transdisciplinary concept and in the long term this should result in the provision of more comprehensive and better co-ordinated services; but it was successfully applied in very few cases. This is in part because it is very time consuming to work as a team. It calls for much sharing and a lot of time communicating, yet time is a precious commodity when there is an urgent need and resources are few. There are other factors that also make creative transdisciplinary team work difficult: high staff turnover and insecurities of staff members where there are different levels of training and thus of prestige. Working with a transdisciplinary team offers many benefits. The support that staff can give to each other raises morale and creates an enthusiastic approach to service; the various activities for the child can be co-ordinated so that common objectives are met by each member of the team; and the increased communication among the team members should result in a unified service and in better communication with parents.

A fourth mode of staffing was that of the single specialist at work with a voluntary team. The primary example of this was the program of the Australian Centre for Brain Injured Children. In this case a professional made use of parents and other volunteers who actually implemented the program under the supervision of that individual specialist. Although a number of programs used volunteers there was a variation in the kind of use that was made of volunteers. In some cases volunteers performed very menial tasks; in others they could be considered true aides to professionals. There are at this stage in Australia very few examples of programs in which volunteers can be considered an integral part of the team.

5.6
THE INFLUENCE OF VARIOUS STRATEGIES OF EDUCATIONAL INTERVENTION

The philosophical orientation upon which any early intervention program is based is important because it influences many aspects of the total intervention service. Although the literature lists many different approaches to educational intervention such as those emphasizing general child development, cognitive development, the provision of responsive environments, direct instruction and modification behaviour, it is very difficult to categorize the early intervention programs in Australia which we studied in this way. It is possible to identify specific philosophies that have influenced the various programs having a research orientation because decisions about staffing, children, program content and style of service delivery in these programs have been made upon the basis of the philosophical standpoint of the researcher. In some cases staff training (for example, influenced by Bobath or Ayres in physiotherapy, Piaget in education, Ling in relation to hearing impairment, Fraiberg in the area of visual impairment) is determined by the philosophy of the program. However, most programs presently in operation in Australia are eclectic, using a mixture of approaches; the balance of the various approaches shifts as changes in staff occur and also as staff discover methods which seem to be most appropriate in their setting.

Most program staff have looked to the development of early intervention programs overseas and to research oriented programs in Australia, particularly those associated with tertiary educational institutions, as a means of guidance for developing early intervention services; the research oriented programs in turn have tended to use model programs from the U.S.A. as prototypes which they have tried to adapt to the Australian context. The philosophical approaches which seem to have had the most impact upon early intervention programs in this country are those emphasizing general developmental stimulation. Obviously the various approaches are not mutually exclusive, most programs reflecting two or more emphases; however the relative emphasis on the various components allows programs to be differentiated and described.

5.6.1
Programs Emphasizing Direct Instruction and Behavioural Analysis Approaches

The use of behavioural analysis methods in educational intervention programs in Australia has tended to be influenced predominantly by work in the U.S.A., particularly the program at the University of Washington, Seattle. Many programs based upon behavioural analysis principles also incorporate direct instructional methods. This was the case with the Macquarie University program for Down's syndrome children aged 0 to 5 years, a program designed to replicate the Seattle program because of that program's success with moderately handicapped Down's syndrome children (Pieterse, 1977). The Macquarie University program had been in operation since 1975 and seemed to have had a considerable impact upon a number of early intervention programs in Australia. Published articles (Pieterse, 1976, 1977, 1979) about the program have been read by many early intervention staff around Australia and program materials devised for the Macquarie project were used in various ways in many programs.

The other main program utilizing behavioural analysis and direct instructional methods was EFIC Children's Centre at Preston Institute of Technology. This program started in 1976 and, like the Macquarie project, the program catered for Down's syndrome children. Articles published about the program (Clunies-Ross, 1976, 1979) have disseminated the results of the project; a videotape, 'Direct Instruction in Early Intervention' has also been produced.

Some Australian programs emphasizing direct instruction have been influenced by the Bereiter-Engelmann pre-school program which was instituted in Illinois in the 1960s. This program attempted to provide a systematic curriculum based upon intensive, carefully sequenced, teacher-directed, small group, verbal instruction. Evaluation of two successive groups (Bereiter & Engelmann, 1966; Engelmann, 1968) showed promising results and on this basis Engelmann and Becker then developed a program which could be applied in kindergarten through third grade. Evidence suggests that direct instruction was the most successful of a variety of approaches tried out in Project Follow-Through (USOE, 1977; Abt Associates, 1977) although there has been considerable controversy over the evaluation (House, et al., 1978). The most well known of these programs are the DISTAR programs published by SRA.

Early studies in Australia using direct instructional methods (Maggs & Morath, 1976; Maggs & Murdoch, 1979) concentrated upon school aged children, but more recently a project at Macquarie University using direct instruction with handicapped children under school age was established by Maggs. These children received a direct instruction program as part of their attendance at their local pre-school. The project co-ordinator taught the pre-school teacher how to implement the program, which was implemented in the local kindergarten or pre-shcool by the pre-school teacher.

The three Australian programs described above have been adopted in full or in part in a number of early intervention programs around Australia. However, the American programs have also had a direct influence upon many programs, as can be seen by the number of programs using assessment and curriculum materials such as Portage Guide to Early Intervention, Engelmann and Bruner's Distar Reading I program and A Curriculum Based Direct Instruction Approach to the Education of Handicapped Infants (Gentry & Adams, 1978). The main British influence seems to be the work of C. Cunningham and D. Jeffree, especially as published in their book, *Working with Parents*.

The influence of behavioural analysis and direct instructional methods is perhaps particularly apparent in the early intervention programs serving mentally retarded or autistic children. Many programs in all states reported using curriculum materials from the Macquarie Project, the Portage Guide to

Early Education (perhaps with adaptations) or materials based on behavioural objectives devised by the program staff. Examples in New South Wales are Marsden Hospital, Newcastle College of Advanced Education, Macquarie Project; in Victoria, Shannon Park Spastic Centre where use is made of a fine grain analysis of objectives, EPIC Children's Centre; in South Australia, Whyalla Early Childhood Resource Centre, Autistic Children's Centre; in the Northern Territory, Down's Syndrome Association of the Northern Territory; in Western Australia, Division for Intellectually Handicapped; and in Queensland, Central Assessment Centre, Autistic Children's Centre. In Western Australia, the Division for Intellectually Handicapped, Irrabeena provides an example of a large government department in which an attempt has been made to use behavioural analysis methods in its service delivery. The Division's programs using the materials devised by staff for their own needs from the Portage Guide to Early Education, and employing social trainers are used in a large network of services. The Central Assessment Centre in Queensland provides another example of a large government department that used a team approach emphasizing behaviourally oriented programs, with systematic recording of the children's progress in terms of target behaviours.

5.6.2
Programs Emphasizing the Principles of General Developmental Stimulation

Although all programs sought to provide general developmental stimulation to some degree, there were programs which emphasized the development of the 'total child'. These program staff did not see their aim as accelerating growth, as would programs such as the EPIC Children's Centre and the Macquarie Project, but rather believed that the program should provide an environment encouraging the child to develop to his or her optimum potential. Emphasis was placed upon the interdependence of aspects of development, and every attempt was made to treat the child's total development and to avoid fragmentation into components such as cognitive structures and specific behavioural skills. The amount of structure varied markedly among programs following the principles of general developmental stimulation because structure in such programs was more likely to be determined by the nature of the activities provided for the child than by behaviour specification and instructions aimed at target behaviours. Programs emphasizing general developmental stimulation are much more difficult to categorize and describe than programs emphasizing principles of behavioural analysis and direct instructional methods. The latter are based predominantly upon reinforcement learning theory, and although there are many interpretations of the limits of reinforcement learning theory and its applications to human development, the accepted principles provide a defined base for program implementation. There is no consensus on a relevant theoretical base for programs following on general developmental stimulation approach. Hence the range of forms of program implementation was much wider, this range reflecting the differing views that then existed about the relationship of developmental theory and practice. Examples of various types of developmental theory are difficult to document; perhaps the best example of what could be described as a program placing emphasis upon a Piagetian model of development is the Exceptional Child Study Centre at the University of Western Australia (Little, 1978).

Programs following the principles of general developmental stimulation also use a wide range of assessment and curriculum materials. The most common materials used by the programs on which we had data were developmental scales such as Bayley and Gesell, norm referenced tests such as the Stanford Binet Intelligence Scales and WPPSI tests and materials such as the Chapel Hill program and the Portage Guide to Early Education. The latter was used by a wide diversity of programs we visited around Australia and provides an example of how the same curriculum materials could be used by programs following different philosophical stances, with the differences in the stances becoming obvious only when the methods of using the materials were studied. Appendix F consists of reviews of the various non-test materials used.

The program of the Autistic Children's Centre in South Australia well exemplifies an eclectic program. The six tenets of the program are presented in 'An outline of the Programmes for Autistic Children and their Families' supplied by the Centre. They incorporate several educational approaches to intervention as well as the broader philosophies such as normalization.

(1) The importance of working with parents as co-therapists.

> The total involvement of parents and family members in the program is required. The staff work with the parents as co-therapists, both in the natural environment of the home and in the Centre or Kindergarten when possible.

(2) The integration of the autistic child into an appropriate educational setting.

> The program is a commitment to mainstreaming, which means the integration of young autistic children into normal play groups and kindergartens, and the placement of all autistic children and adolescents into appropriate educational and work settings according to their capabilities.

(3) The utilization of behaviour modification techniques.

> An essential feature of the program is the use of behaviour modification techniques to develop positive approaches for learning, to control disturbed behaviour and autistic mannerisms, to assist in the teaching of new skills, to maintain existing levels of behaviour as well as to assist the transfer of learned behaviours and skills to the home setting.

(4) The value of structured teaching approaches.

> The need for structured teaching approaches and a structured environment is a valued aspect of the program. A structured program denotes that the

learning environment has been carefully evaluated and that the learning experiences given the child will be planned and implemented in correct learning sequences, as a result of the setting up of objectives, the use of certain teaching strategies, and a high degree of external organization and control.

(5) The implementation of a developmental approach to learning.

A key feature of the program is the emphasis on developmental programing. The developmental approach has a number of built-in concepts. Firstly, it involves a theoretical rationale on the relationship between normal development and the abnormal development of autistic children - many aspects of disturbed behaviour in autistic children can be seen as early developmental responses, which only occur for brief periods in the normal child's development, but remain fixed and rigid in the development and behaviour of autistic children unless developmental programing is carried out. Secondly, it involves a full assessment of the child's levels of functioning and his strengths and weaknesses, through developmental assessment profiles such as the Portage, and Piagetian-based scales. (Jean Piaget, a Swiss psychologist, has outlined a theory of early development, which is used as the basis of much of our early programing). Thirdly, developmentally appropriate skills can then be built up, areas of high skills strengthened, and areas of low skills systematically analysed and effective programing implemented. Fourthly, a developmental approach also emphasizes the individualization of each program according to the child's needs and developmental profile.

(6) The belief in the necessity for total consistency within each area of programing, and between each section of the program.

It is regarded as vitally important that all professionals concerned with the child, and the child's family itself, must work as a single team, and each must be totally informed of every minute step of the program. This means that all involved with the child will not only understand "what" we are doing and "why", but also there will be total consistency in teaching approaches. The management approaches that the staff decide to implement will therefore also need to be carried out in the same way by every person concerned

5.7
DISCUSSION OF QUESTIONNAIRE DATA

One hundred and thirty-three questionnaires were submitted by the directors of early intervention programs which met the definitional criteria used in our study.* The data provided by these questionnaires are presented in tabular form in the following sections.

Table 5.1

Response to Survey of Early Intervention Programs: by State

State/Territory	No. of programs meeting definitional criteria	No. of programs returning questionnaires	% Return
New South Wales	40	35	88
Victoria	41	38	93
Queensland	20	19	95
South Australia	16	12	75
Western Australia	13	11	85
Tasmania	13	11	85
Northern Territory	2	2	100
A.C.T.	5	5	100
Total	150	133	87

Table 5.1 shows both the number and percentage of programs, differentiated by State, for which questionnaires were submitted.

Table 5.2 presents information concerning the location of the 150 programs identified and the number of programs in relation to the total population of the different locations.

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* See Section 3.1.2, pp. 18-21

Table 5.2

Number of programs in cities and towns with more than 11,000 residents

Town	State	Population (x000)	No. of programs	Town	State	Population (x000)	No. of programs
Sydney	NSW	2930	25	Burnie	TAS	21	1
Melbourne	VIC	2650	29	Devonport	TAS	21	-
Brisbane	QLD	925	15	Kalgoorlie	WA	21	-
Adelaide	SA	895	14	Shepparton	VIC	21	1
Perth	WA	775	13	Armidale	NSW	21	2
Newcastle	NSW	275	1	Maryborough	QLD	20	1
Wollongong	NSW	220	2	Warnambool	VIC	20	1
Canberra	ACT	185	6	Bunbury	WA	19	-
Hobart	TAS	142	9	Dubbo	NSW	19	1
Geelong	VIC	127	1	Moe/Yallourn	VIC	18	-
Gold Coast	QLD/NSW	95	-	Mt. Gambier	SA	18	-
Townsville	QLD	81	2	Gladstone	QLD	18	-
Launceston	TAS	65	4	Bathurst	NSW	18	-
Toowoomba	QLD	52	-	Geraldton	WA	17	-
Ballarat	VIC	61	1	Morwell	VIC	17	-
Rockhampton	QLD	51	1	Cessnock	NSW	17	1
Bendigo	VIC	50	2	Grafton	NSW	17	1
Darwin	NT	45	2	The Entrance	NSW	16	-
Gosford/ Woy Woy	NSW	45	-	Wangaratta	NSW	16	-
Albury/ Wodonga	NSW/ VIC	45	1	Port Pirie	SA	16	1
Whyalla	SA	39	1	Traralgon	VIC	15	-
Cairns	QLD	34	1	Nowra	NSW	14	1
Broken Hill	NSW	30	-	Albury	WA	14	-
Mackay	QLD	30	1	Mildura	VIC	13	-
Wagga Wagga	NSW	29	-	Lithgow	NSW	13	-
Bundaberg	QLD	28	-	Port Augusta	SA	13	-
Mt. Isa	QLD	28	1	Taree	NSW	13	1
Tamworth	NSW	27	-	Griffith	NSW	12	-
Maitland	NSW	26	-	Sale	VIC	12	-
Orange	NSW	26	-	Horsham	VIC	11	1
Goulburn	NSW	23	-	Gympie	QLD	11	-
Lismore	NSW	22	-				

Five other programs were located in small towns with populations of less than 10,000.

5.7.1
Date of Establishment of Programs

Most respondents provided data recording when their programs were established. Discussion with staff members at workshops or during site visits, however, revealed that some organizations considered that they had been providing Early Intervention Programs (E.I.P.) for longer periods than indicated, although these programs may not have been specifically designated as early intervention. In some instances, the E.I.P. represented a change, either in approach or in intensity, to an existing program.

In most States early intervention for the hearing impaired pre-dated such services for any other disability group.

Table 5.3

Decade in which E.I.P. began

(n = 129)

Years	No. of programs	%
prior to 1950	1	1
1950-59	9	7
1960-69	13	10
1970-79	106	82

Of the four programs not included in this table, two did not reply and two began in 1980.

Table 5.3 provides details concerning the introduction of early intervention programs, including experimental and pilot programs, by decade, for the period extending from the years prior to 1950 to 1979.

Of particular interest is the finding that 106 (82 per cent) of the programs were established in the period 1970-1979. Of these, 81 (75 per cent) were introduced during the second half of the decade (Figure 5.1). Any projection of this growth rate for the current decade would involve estimates of need in areas not yet served by early intervention.

Figure 5.1

No. of programs established from 1970-1980, by year of origin

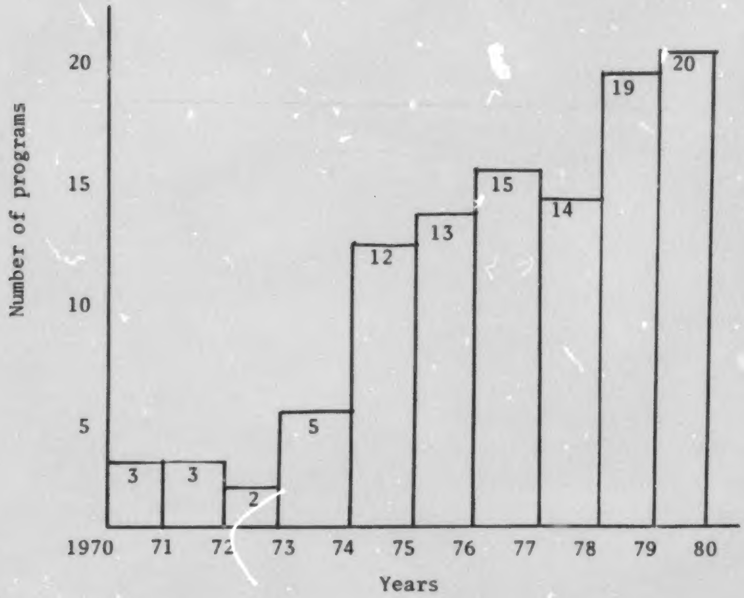

Table 5.4 provides information concerning the introduction of new programs, by year of origin, in terms of their location.

Table 5.4

Location Site of program, by year of origin

Location	1975	1976	1977	1978	1979
Sydney	4	2	3	2	2
Melbourne	3	2	4	4	2
Brisbane	-	1	-	2	3
Adelaide	2	1	1	1	-
Perth	1	1	2	-	3
Other capitals	-	2	2	1	2
Towns > 40,000	1	3	1	3	2
Towns 11,000-40,000	2	2	-	4	3
Other places	-	1	1	2	3

5.7.2
Number of Children Served

The data concerning the number of children served by E.I.P.s need to be viewed with some caution. Misinterpretation of this item by some respondents resulted in the provision of information concerning the total number of children receiving programs under the auspices of an organization, rather than the number of children enrolled in the early intervention component. In addition, some organizations did not distinguish between programs on the basis of chronological age. They viewed their programs from a developmental life span perspective ranging from infancy to adulthood. In some instances, therefore, the data are estimates; in others, no information concerning numbers of children served was provided.

Some respondents failed to differentiate between non-handicapped and handicapped children participating in their programs. Of the 5411 children enrolled in E.I.P.s 254, or slightly less than five per cent, were identified as non-handicapped. This result reflects the deliberate exclusion from the study of regular preschools which integrated one or two disabled children, with little or no special intervention provided. Twenty-five per cent (34) of the programs included some non-handicapped children. Two of these programs catered for more non-handicapped than handicapped children. Ten programs served approximately equal numbers of handicapped and non-handicapped youngsters. The remainder (22) enrolled more handicapped than non-handicapped children. These data are set out in Table 5.5.

Table 5.5

Number of children, including non-handicapped, enrolled in program

Number of children in program	Programs with:				All programs	
	Handicapped children only		Handicapped and non-handicapped			
	(n = 99)		(n = 34)		(n = 133)	
	N	%	N	%	N	%
10 or less	33	33	6	18	39	29
11-20	19	19	12	35	31	23
21-30	19	19	4	12	23	17
31-50	7	7	4	12	11	8
51-100	11	11	2	6	13	10
100	10	10	6	18	16	12

Some of the non-handicapped children in the E.I.P.s were siblings of disabled youngsters; others were children whose inclusion served the primary purpose of providing a normal peer group for the handicapped youngsters.

Within the handicapped population the male/female ratio was approximately 122/100, by comparison with the national birth ratio of 106/100.

Table 5.6

Number of handicapped children by location of program

Area	Total number of children	Number of programs
Sydney	1130	23
Melbourne	942	23
Brisbane	857	13
Adelaide	481	10
Perth	487	11
Other capitals	383	15
Towns 40,000	327	13
Towns 11,000-40,000	294	13
Other places	256	12
Total	5157	133

Table 5.6 provides data on the number of children receiving early intervention services in each location.

5.7.3
Age of Children

The number and percentage of children in receipt of early intervention services, and the number and percentage of programs catering for the different age levels are set out in Table 5.7.

The questionnaire item which sought this information was also interpreted by some respondents as referring to the total number of children receiving services, rather than being restricted to those involved in early intervention programs. The data for the category '6 years and over', therefore, are likely to be inflated. The missing data reflect the number of programs unable to supply the relevant breakdown by age level for children receiving services.

Table 5.7

Breakdown of clients' age

Age range	Number of children	% (n = 4559)	Number of programs serving these children
under 6 months	77	2	17
6-11 months	326	7	49
1 year-1 yr 11 mnths	598	13	72
2 years-2 yrs 11 mnths	796	18	93
3 years-3 yrs 11 mnths	841	18	108
4 years-4 yrs 11 mnths	819	18	101
5 years-5 yrs 11 mnths	497	11	82
6 years or more	605	13	49
missing data	852		

Of the 4559 children in receipt of early intervention services differentiated by age level, 22 per cent were under the age of two years, 54 per cent in the range from 2 years to 4 years 11 months and 24 per cent 5 years of age and over.

5.7.4
Impetus for Program Establishment

Table 5.8 lists influences leading to the establishment of services of early intervention.

Table 5.8

Impetus for service provision (n = 120)

Primary influences	N	Ranking
Concerned parents	35	1
Desire to service unmet need	33	2
Concerned professionals	26	3
Recognition of contribution from early intervention	13	4
Needs established by survey	11	5
Government departments	7	6
Voluntary organizations	7	6

The influences listed in the above table are clearly not discrete categories, and there is obvious overlap between items such as concerned parents, desire to service need, and concerned professionals. The rankings of the influences leading to program establishment therefore need to be interpreted with caution.

5.7.5
Nature of Change in Programs

Eighty per cent of programs had undergone a major change in direction since their inception. The most frequent change had been the conversion from a child-minding or playgroup facility to a training program. Ninety programs underwent this conversion. Within these programs, there was a fairly even distribution between two major component changes: gaining more structure, variously described as constructive planned program for each child, more academic work - pre-reading and pre-writing, direct instruction programs; and a major staff change such as extension of medical and paramedical services, more professionals, visiting teachers and so on.

Twelve programs now catered for a younger age group than originally planned. Five programs placed greater emphasis on parent involvement than previously, with one of these discontinuing centre based programs in favour of an increase in home based intervention.

5.7.6
Sources of Funding

Table 5.9 lists the sources of funding under the headings of primary, secondary and other funding.

Table 5.9

Sources of funding

Source	Primary funding (n = 133)		Secondary funding (n = 96)		Other funding (n = 48)	
	N	%	N	%	N	[illegible]
Federal government	29	22	22	23	0	-
State governments Health/Welfare (31) Education (33)	64	48	6	6	6	13
Voluntary organizations	10	8	7	7	3	6
Donations/Fundraising	8	6	42	43	33	69
Fees/Subscriptions	1	1	11	12	4	8
Combinations of above*	21	16	8	8	2	4

*Commonly involving some governmental responsibility, usually for salaries.

The major primary funding source therefore was government based, the major secondary funding source was the donations/fundraising category. Thirty-seven programs had only one funding source.

5.7.7
Administrative Setting

The administrative setting of the programs is represented in Figure 5.2.

Figure 5.2

Administra[illegible]ting of programs

n = 129

	Education departments		Health/ Welfare departments		Established voluntary or religious organizations		Parent groups		Other (tertiary institution independent school)	
	N	%	N	%	N	%	N	%	N	%
Number of programs	33	26	29	23	50	39	9	7	8	6

On a national scale, the largest number of early intervention programs (39 per cent) were provided by voluntary and religious organizations. The contribution from Education Departments was 26 per cent, and from Health and Welfare 23 per cent. Programs supported by parent groups comprised 7 per cent. The remaining 6 per cent were sponsored by groups such as independent schools or tertiary institution departments.

The division of Education Departments, State or Commonwealth, generally charged with the responsibility for early intervention services for handicapped children, was a special services or a guidance and special services branch. The division administering pre-school services might also be involved. Health Departments contributed through three main sources: special services divisions such as Mental Retardation or Intellectual Handicap Services; Hospitals; and Community Health Services. Welfare services made a contribution by sponsoring, either wholly or partially community programs broadly conceived as early intervention (although these may not have met the definitional criteria employed in the study).

In voluntary organizations, authority was usually vested in a board of management or board of trustees. The relationship between the board and the early intervention program was usually an indirect one. As a general rule, the program director or co-ordinator worked through the administrative staff of the organization to seek funding and other assistance from the board. In programs observed during site visits, the relationships between program directors and co-ordinators and the administrative staff were fairly close, both in terms of the number of administrative steps between them and in terms of possibilities for personal contact.

Programs supported by parent groups and governed by management committees generally fostered the closest relationship between program staff and the board, usually because the program of early intervention was the reason for the board's existence.

The remaining programs were administratively related to groups such as management boards of independent schools or to tertiary institution departments.

5.7.8
Base

Respondents were asked to supply information on children who received the following three types of service:

A. Home-based program - a program implemented in the child's own home, whether by trained parents or professional home visitors, and possibly involving the child's visit to a centre no more than once per month.

B. Centre-based program - a program requiring that children attend a centre whether this is a permanent facility, a mobile unit, or a private residence, and possibly involving home visits to the child no more than once per month.

C. Integrated Home/Centre-based program - a program providing both Home-based and Centre-based services to the same children.

Table 5.10

Base of services

Base	Number of programs n = 133	%
Home based only	6	5
Centre based only	61	46
Integrated Home/Centre based	13	10
Home and centre based	13	10
Home and integrated	7	5
Home, centre and integrated	21	16
Centre and integrated	12	9

Of the 4186 children in receipt of services, one-quarter (1034) received home-based, fifty-six per cent (2332) received centre-based and one-fifth received integrated home/centre based programs. Table 5.11 shows the location of the programs and the number of children involved.

Table 5.11

Number of children, type of service and the location of program

Area	Children in:		Integrated
	Home-based programs	Centre-based programs	programs
	N	N	N
Sydney	236	508	67
Melbourne	256	528	151
Brisbane	181	251	211
Adelaide	88	193	124
Perth	110	235	67
Other capitals	16	312	-
Towns > 40,000	4	197	84
Towns 11,000-40,000	80	66	60
Other places	63	42	56

The definition of a home-based program allowed for an occasional visit to a centre by the child, limited to no more than one per month. The wording ensured that home-based services requiring an infrequent visit to a centre for assessment could be clearly identified as a home-based program. The definition was also intended to include two kinds of programs: a) a program in which the professional trained the parent in the home so that the parent could then carry on the program, or b) one in which the professional worked and played with the child with or without the parent's participation. The site visits suggested that no home-based programs were carried out by professionals without parental involvement. Because programs offering family training only were not included in the study a home-based program as here defined does not include a program such as the South Australian Family Training Unit or Intellectually Retarded Services that trains parents in a centre and then asks the parent to implement the program at home. Instead, a home-based program as defined for inclusion in the questionnaire data assumes some professional involvement with the child, direct rather than indirect.

The category of centre-based program permitted home visits as often as once per month, for the sake of reporting to parents. However, in practice visits to children in their homes were much more infrequent in centre-based programs.

5.7.9
Types of Disabilities Served

Respondents were asked to classify children in receipt of services according to their primary disability. A child with mild cerebral palsy and severe mental retardation, for instance, would be classified as primarily mentally retarded.

Understandably many program staff were reluctant to identify children according to primary disability, partly because, in many cases, it was difficult to assign one disability as having more importance for the child's development. It must be recognized that the figures for mental retardation and physical disability could indicate children who are multiply handicapped but who nevertheless have a clear predominance of one disability. Although programs that dealt only with children having emotional disabilities or behaviour problems, or children environmentally deprived, were not investigated, a category 'other' was provided to allow for identification of such children if they had been incorporated into programs. In fact 86 children were regarded as fitting this category although when a description of their disability was provided it ranged over exceptional physiological, psychological and environmental factors.

If a child suffered more than one major disability, respondents were asked to use the category 'multiply handicapped'. Table 5.12 provides information on the types of disabled children served by programs.

Although one might expect most programs to be specialized or to grow out of specialized services for children with one primary disability, only 35 per cent of programs in the questionnaire data served children who could all be identified as having the same primary disability. (Most of these were programs serving only children who were mentally retarded or who were hearing-impaired.) The remaining 65 per cent of programs were "multidiagnostic", that is, serving heterogeneous groups of children, some having one predominant disability and others having other primary disabilities. The largest group of these programs consisted of those serving children who had either of two primary disabilities (Table 5.12). Thirty-six (70 per cent) of the 51 programs stated that for some of their children mental disability was the primary disability. This was the case also for sixty-nine (80 per cent) of the multidiagnostic programs. When programs serving homogeneous groups were considered as well, 97 (75 per cent) of all early intervention programs in the questionnaire data served some children with a mental disability. In all, sixty-nine programs (53 per cent) had some children who were multiply handicapped, that is, children with more than one major disability.

These figures are consistent with field observations suggesting that many groups originally established to serve children with one primary disability were finding it necessary to revise their criteria to serve young disabled children with various disabilities, either because suitable programs were lacking or because a community-oriented program must necessarily serve the heterogeneous children within its neighbourhood. The figures are also consistent with the impression of many program operators who communicated to the researchers their feeling that they were seeing more children, currently, who had multiple disabilities than they saw in the past.

Table 5.12

The primary disability of children in programs

(n = 130)

Mental retardation	Physical disability	Hearing impairment	Visual impairment	Multiply handicapped	Number of programs	%
X					28	22
	X				1	1
		X			10	8
			X		1	1
				X	4	3
X	X				10	8
X	X	X			5	4
X		X			2	2
X	X		X		2	2
X			X		1	1
		X	X		1	1
X	X			X	14	11
X				X	23	18
	X			X	3	2
		X		X	6	5
X	X	X		X	1	1
			X	X	5	4
X	X		X	X	6	5
	X		X	X	1	1
X		X	X	X	1	1
		X	X	X	1	1
X	X	X	X	X	4	3

Table 5.13 describes programs in terms of the number of children within each disability category.

Table 5.13

Number of programs by size of disabled clientele

(n = 133)

No. of Children	Mental retardation	Physical disability	Hearing impaired	Visually impaired	Multiply handicapped
	N	N	N	N	N
None	39	88	104	112	67
1-5	28	26	12	12	42
6-10	23	4	2	3	11
11-20	13	4	5	-	6
21-50	18	5	7	4	4
> 50	12	6	3	2	3

5.7.10
Parents' Groups, Meetings and Workshops

Parents' groups had been established in three-quarters of the programs. Table 5.14 sets out the major function of these groups.

Table 5.14

Function of parent group

(n = 130)

Primary purpose	N	%
Parent and Citizen functions (fundraising, social)	54	42
Parent support	32	25
Executive decision-making	9	7
No parent group	35	27

Twenty-five programs provided meetings of an informal nature, e.g. 'provide relevant information and discuss topics of interest', 'informal coffee mornings', 'group meetings and/or barbeques for parents'. The remainder, however, provided meetings or, more commonly, workshops on a more rigorous or formal base - 'behaviour modification training', 'total communications instruction for parents of hearing impaired children', 'parent training group', 'annual twelve week course in child management and home training'.

5.7.11
Communications with Parents

Table 5.15 lists the regular methods of communication with parents. Twelve programs did not communicate regularly with parents by any of the means listed. Four of these were programs administered by parents and further communication was thought to be unnecessary.

Table 5.15

Regular methods of communicating with parents

(n = 133)

Method	N	%
General newsletter	54	41
Written progress reports for each child	45	34
Arranged meetings with parents	98	73
Informal meetings with parents	112	84
Telephone conversations	98	73

5.7.12
Facilities

For those programs with a centre-based component (127 programs), the type of building in which the program was housed ranged from an Ambulance Brigade Hall to purpose-built facilities with a large range of special purpose rooms.

Forty-one programs provided services from within, or adjacent to, regular or special schools (both government and nongovernment). Five were located in hospital grounds, ten operated from church or community halls with varying degrees of modification and suitability. Twenty per cent (27 programs) regarded their centre as temporary and commonly noted that accommodation was contingent upon funding (normally government), renovation of existing premises or construction of new facilities in varying stages of completion.

Approximately one-fifth of programs mentioned therapy facilities, e.g. special language room, gymnasium, treatment rooms, swimming pool. Seven programs specifically mentioned assessment facilities.

5.7.13
Outdoor Play Areas

Of the 127 programs that described the outdoor play areas available to the children, nine mentioned that there were no such areas provided for the children or that the areas provided were inadequate. In the others, a wide range of outdoor play facilities was provided. Those mentioned included adventure playgrounds, swings, climbing equipment, trampolines, sand pits, heated pools, water play equipment, garden areas, areas for bicycles and grassed areas for running etc.

5.7.14
Staffing

Table 5.16 provides a program breakdown on paid staff and volunteers.

Table 5.16

Number of staff

Number of staff	Paid full time n = 133		Paid part time n = 133		Volunteers n = 133	
	N	%	N	%	N	%
1-5	79	59	66	50	40	30
6-15	19	14	21	16	16	13
16-30	6	5	2	2	4	3
>30	1	1	3	2	6	5
no such staff	28	21	41	31	67	51

The relationships among these staff categories are presented in Table 5.17.

Table 5.17

Relationships among staff categories

(n = 116)

Programs with:	Number of programs	%
paid full time staff only	20	17
paid part time staff only	11	9
volunteers only	2	2
full time and part time staff	28	24
full time and volunteer staff	11	9
part time and volunteer staff	9	8
full time, part time and volunteer staff	35	30

Programs were asked to list the number of staff, average hours spent, and type of service provided by professional disciplines. This was a difficult item to answer, for if the service was offered to more than the early intervention clientele, an estimate of hours spent had to be made. In other cases the section on average hours worked was not completed and five programs ignored the whole section on staffing. Consequently Table 5.18 gives details on professional staff providing services, but time spent could be as low as only half an hour per week or as much as full time. With the above reservations the average and the most common number of hours (mode) spent per person are included in Table 5.18.

Table 5.18

Availability of professional staff

(n = 128)

Programs with:	Number of programs using this profession	%	Average hours worked per professional per week	
			mean	mode
Occupational therapists	51	40	14	1
Speech therapists	56	44	9	1
Physiotherapists	72	56	11	4
Teachers	96	75	25	40
Social workers	37	29	16	1
Psychologists	47	37	11	1

Respondents experienced difficulty with the 'psychologist' category in Table 5.18. Some included under this category visiting guidance branch staff from the respective education departments, while others included these participants in a miscellany of other professional services available to the program. Consequently the figures in this category may represent an underestimate.

It should be noted that greater involvement of therapists may exist in treatment programs or other services offered to disabled children, but in early intervention programs more programs employed teachers than any other single category of professionals. Teachers also worked more hours per week on average than any other single group of professionals. Next in numerical importance to teachers were physiotherapists, with 72 of 128 programs using physiotherapists in their service.

5.7.15
Transportation

The transportation of children to and from centre-based programs was no problem in 54 per cent of cases. Parents usually provided the transport, often with the assistance of volunteers. In some cases buses or taxis were provided.

For just over a third of the programs, however, there were problems involved in transporting the children. The major problems encountered were:

(a) the time involved in transporting the children to the programs because in many cases children lived a long way from the centres,

(b) the excessive cost of transport (both private and public),

(c) the inability of parents to provide transport,

(d) the inadequacy of public transport.

5.7.16
Publicity

Apart from the ubiquitous newsletter, brochure or pamphlet, publicity ranged from blanket media coverage with the twin aims of increasing public awareness of a service or a disability and as a fund raising tool, to more specific target populations, e.g. communication with paediatricians, infant welfare sisters, or visits by medical and paramedical students and workshops for others in related services. The aim of this specific publicity was to inform relevant professionals and agencies of services. Almost all programs appeared to have a newsletter or a part of a newsletter (e.g. as a member of an umbrella organization). The recipients were usually the parents of children in receipt of services. Twelve programs used little or no publicity, five because the program was based on established referral procedures and one because it 'would be inundated with children'.

Approximately one third of programs had, in 1979, participated in a major media event, such as Radiothon', 'Blindness Week', 'Under Fives Week', 'Quest of Quests', 'Handicapped Persons' Month of IYC'. Almost half participated in television or radio events ranging from advertisements and interviews to dedicated programs, with one program hiring a public relations firm to arrange publicity.

Most programs had access to popular printed media, again with varying degrees of comprehensiveness and regularity. However, the publicity that 121 programs found most effective was 'word of mouth'.

5.7.17
Attendance at Conferences and Seminars

The staff of three quarters of the programs attended conferences or seminars outside the program ; Table 5.19 indicates the number of paid staff attending.

Table 5.19

Staff attending outside conferences

(n = 125)

Number of staff	Number of programs	%
One staff member	24	19
Two staff members	26	21
Three to five staff members	22	18
More than five staff members	14	11
No staff members	39	31

Table 5.20 attempts to describe the primary focus of the conferences. Any one conference could have many different entries, depending on the respondents' interpretation of the primary subject matter.

Table 5.20

Focus of conferences and seminars

Primary focus	Number of programs
A disability	54
Therapy/caring	15
Intervention	13
A developmental method	13
Academic skills	7
Normalisation/placement	5
Not directly involving early childhood education	9

5.7.18
Assessment Methods and Program Materials

Of the 130 programs replying in this section, 120 used at least one formal assessment method, where 'formal' implies some sort of repetitive, consistent scaling technique that facilitated temporal comparisons of progress. For example, a program for hearing impaired children specified:

> 'a broad battery of audiological assessments and psychological ones - intelligence (performance), verbal abilities, personal-social adjustments, etc.'

and The Centre for Brain Injured Children wrote:

> 'measurement is made using the Sandler-Brown Developmental Profile by means of a Functional Neurological Evaluation, looking at the three major sensory areas (vision, auditory and tactile) and the three motor areas (mobility, manual and language)'.

Sixty programs, almost half of the population, used only formal assessment methods to monitor the progress of children, either administered by program staff or other agencies (e.g. Guidance Branch of Education Department). The remaining 60 programs employed formal assessment methods but also employed subjective evaluation methods, generally including case studies of each child with the intuitions of program staff, parents, or support services staff. For example:

> 'frequent assessment by teachers, physiotherapists and speech therapist - all compile written reports, home visit reports, Low Vision Clinic assessment reports; Guidance Officer's report; anecdotal records or "informal assessment" from records, video, and formal assessment'.

The remaining ten programs either used subjective or impressionist evaluation methods. A sample of responses included: 'some record keeping of child's progress by teacher and parent but no time for assessment here'; 'formal assessment was used but found inappropriate; 'teachers now use any method they feel fits' or 'haphazard, as a non-professional person running program'.

Table 5.21 lists alphabetically all commercially available materials, checklists and/or tests used by two or more programs. No attempt has been made to separate this material by function as many, e.g. Seattle, Macquarie, and Chapel Hill, have multiple uses. The most common name is used for the material where applicable, and some relevant bibliographical information is included where available. While the material supplied was ostensibly 'commercially available', many have been modified and some have been devised locally and should not strictly be classified as 'commercially available'.

Materials named by only one program in the population do not appear in Table 5.21.

Table 5.21

Materials used by programs

Name	Number of programs in which material is in use
Assessment of Deaf Blind Children: The Callier-Asuza Scale R.O. Stillman. CEC: Reston, VA. 1974 Assessment: Motor, Socialization, Daily Living, Perceptual, Language. CA - birth to 6 or 7	4
Bayley Scales of Infant Development V. Bayley. Psych. Corp., New York. 1969 Assessment: Mental, Motor, Infant Behaviour. CA - birth to 2½ years.	9
Behavioural Characteristics Progression Checklist: provides comprehensive chart of pupil behaviours. CA - young adult. BORT Corp., Palo Alto, CA. 1973.	7
Chapel Hill Training Outreach Project Materials North Carolina: Kaplan Press Learning Accomplishment Profile (LAP) Sanford, CA. 1974 Range - birth to 72 months. Assessment: Gross Motor, Fine Motor, Self Help, Cognitive Language and Social Abilities.	6
Curriculum Guide. Hearing Impaired Children - birth to three years - their parents Winifred Northcott. Washington, D.C.: Alexander Graham Bell Association for the Deaf, 1972.	3
Developmental Activities Screening Inventory (DASI) R.F. Du Bose and M.B. Langley. New York: Teaching Resources Corp. 1977 Range: 6 months to 5 years	4
Denver Developmental Screening Test, Rev. Ed. W.K. Frankenberg, J.B. Dodds and A.W. Fandel. Denver: University of Colorado Medical Center. 1970 Assessment: Gross - Fine Motor, Language - Personal Social CA - birth to 6 years	12
The Developmental Progress of Infants and Young Children. Mary I. Sheridan. NFER. 1973 Range: Birth to 5 years	7
Developmental Test of Visual-Motor Integration. K. Beery. Follett Ed. Corp., Chicago, 1967 Assessment: Visual Motor. Range - 2.10 to 15.9	2

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Table 5.21

Materials used by programs

Name	Number of programs in which material is in use
The Development of the Infant and Young Child: Normal and Abnormal R.S. Illingworth. London: E & F Livingstone, 1967.	3
Distar kits Chicago: Science Research Association, 1969. Range: preschool and lower primary. Assessment: Language, Reading, Arithmetic	5
Down's Syndrome Performance Inventory. University of Washington, College of Education, Child Development and Mental Retardation Center, Seattle, WA. Range: infancy to preschool	6
Environment Language Inventory J.P. McDonald. Children with severe language delay, part of Environmental Language Intervention Strategy. See: J.D. MacDonald & J.P. Blott, Environmental Language usage intervention: The rationale for a diagnostic and training strategy through rules, context and generalization. Journal of Speech and Hearing Disorders, 39(3), pp. 244-256	5
Frostig Program for the Development of Visual Perception Follett Pub. Co., Chicago, 1964 Range: preschool to year 1. Remedial: years 1-6. Assessment: Visual Perception	8
Gesell Development Schedules Psych. Corp., New York Assessment: Motor, Adaptive, Language, Personal Social CA - 4 weeks (or less) to 6 years	4
Griffith Mental Development Scales for Testing Babies and Young Children from birth to 8 years. R. Griffiths. The Test Agency (Hywickam, Bucks., U.K.) (Cournswood House, North Dean) See also: Abilities of Babies, Abilities of Young Children	4
Guide to Early Developmental Training Wabash Centre for the Mentally Retarded, South Plympton, SA: Helios Art and Book. Boston: Allyn & Bacon, 1977	7
Hawaiian Early Learning Profile	2
ITPA Illinois Test of Psycholinguistic Abilities: Revised Ed. Kirk, McCarthy, Kirk. Urbana, Ill.: University of Illinois Press, 1968. Assessment: Language. CA - 2 years 4 months to 10 years 3 months	5

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Table 5.21

Materials used by programs

Name	Number of programs in which material is in use
Language Development Programme Sheila Drummond	2
LARSP Crystal, D. in D. Crystal, P. Fletcher and M. Garman The Grammatical Analysis of Language Disability. New York: Elsevier, 1975	2
Macquarie University Down's Syndrome Program Assessment and Curriculum Materials Assessment Performance Inventory Revised, 1979 Birth to 5 years. Curriculum Guide for Intellectually Handicapped Children Birth to 4 years Reading Program, Revised 1979. S. Cairns and M. Pieterse Number Skills Program. B. Thorley, V. Woods, M. Pieterse and S. Cairns Milestones in Motor Development. M. Pieterse Birth to 6 months Nutrition and Feeding Program. M. Pieterse 3 to 35 months Infant Exercises. 0 to 18 months	9
McCarthy Scales of Children's Abilities. P. McCarthy. Psych. Corp., New York, 1972 Range: 2½ to 8½ years Assessment: Verbal, Perceptual-Performance, Quantitative, General Cognitive, Memory, Motor	2
Merrill Palmer Scale of Mental Tests Chicago: Ctl Stoelting, 1931 CA - 24 to 63 months Assessment: Mental Age	4
Milani-Comparetti Motor Development Screening Test, Recently Rev. See: Pattern Analysis of Motor Development and its Disorders, Milani, Comparetti and Gidonis. Developmental Medicine and Child Neurology, 9, 1965, pp. 625-630. Routine Developmental Examination in Normal and Retarded Children. Devel. Med. & Child Neurology, 1967, p. 637.	2
Neale Scales of Early Childhood Development Chicago: Scientific Research Associates, 1976 Range: 3½ to 5½ years	2
Oregon Project for visually impaired and blind preschool children	2

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Table 5.21

Materials used by programs

Name	Number of programs in which material is in use
Peabody Developmental Motor Scales Nashville, Tenn.: George Peabody College for Teachers, Institution on Mental Retardation and Intellectual Development, 1974	16
Perceptual-motor lesson plans: Basic and "practical" lesson plans for perceptual-motor programs in preschool and elementary grade. Jack Capon. Alameda, Calif.: Front Row Experience, 1975	2
Portage Guide to Early Intervention Developmental Checklist. CA - birth to 6 years Assessment: Infant Stimulation, Socialization, Language, Self-help, Cognitive, Motor Portage, Wisconsin: CESA, 1975	54
Progress Assessment Chart of Social Development Guinsberg. SEFA Publications Social Assessment: Generally (moderately) intellectually handicapped children and adults. Four main areas: self-help, communication, socialization and occupation.	8
Southern California Sensory Integration Tests Jean Ayres. Los Angeles: Western Psychological Services	3
Stanford-Binet Intelligence Scale - Third Edition - Form L-M Rev. Houghton Mifflin, 1960 To obtain mental age. CA - 2 years to adult.	7
Reynell Developmental Language Scales - Revised Edition J.K. Reynell. Windsor, England: NFER, 1977 Language Assessment, severely handicapped children CA - 1½ to 6 years	13
San Juan Handicapped Infant Project San Juan United School District, Carmichael, CA, 1975	2
Schedule of development in audition, speech, language, communication for hearing-imparied infants and their parents. Agnes H. Ling. Washington, D.C.: Alexander Graham Bell Association for Deaf, 1971. Hearing impaired	8
A Step by step learning guide for retarded infants and children V.A. Johnson and R.A. Werner. Syracuse, New York: Syracuse University Press, 1975.	2

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Table 5.21

Materials used by programs

Name	Number of programs in which material is in use
Talk to me Jerome G. Alpiner. Baltimore: Williams and Wilkins, 1977. Hearing impaired: infancy to preschool	3
Teaching Your Down's Syndrome Infant: A Guide for Parents Marci J. Hanson. Baltimore: University Park Press, 1977 Materials - Teaching Activities for parents and professionals - devised for Down's Syndrome Infant-Parent Program	10
Test of Basic Concepts A.E. Boehm. Psych. Corp., New York, 1971. CA - preschool, year 1 and 2 Assessment: Mastery of Concepts	7
Vineland Social Maturity Scale E.A. Doll. Australian Edition: ACER, 1949 Desires a social quotient CA - birth to maturity	3
Vulpé Assessment Battery for the atypical child S.G. Vulpé. Toronto: National Institute on Mental Retardation, 1969. Range: birth to 5 years	3
WPPSI Wechsler Preschool and Primary Scale of Intelligence D. Wechsler. The Psychological Corporation, N.Y., 1967 Test: Intelligence - Verbal and Performance CA - 4 to 6½ years	5
WISC-R Wechsler Intelligence Scales for Children - Revised D. Wechsler. The Psychological Corporation, N.Y., 1974 Test: Intelligence - Verbal and Performance Scales CA - 6 to 16.11 years	4

CHAPTER 6

EARLY INTERVENTION PROGRAMS: PARENT PERSPECTIVES

A.J.Coulston & W.C.Apelt

Data on parents' perceptions of early intervention came from two sources; mailed questionnaires completed by a sample of parents and discussions at the workshop in each capital city.

6.1
PARENT QUESTIONNAIRE DATA

Questionnaires were distributed to parents of handicapped children enrolled in 28 early intervention programs throughout Australia.[1] These programs fulfilled two criteria:

1. The program had received a full day visit from one of the research teams.
2. The program staff had agreed to distribute questionnaires to parents of children in their program.

Six hundred and eighty-nine parents returned completed questionnaires. Of these, 410 were completed by the mother, 142 by both parents and 64 by the father. Sixty-three questionnaires were completed with a person other than the parent present: in 21 cases, a research team member and in 42 a member of the program staff. The remainder were completed by persons other than the parent, mainly for reasons associated with language facility.

The questionnaires requested some information concerning the child and the type of service provided. The major concern of the questionnaires, however, was to explore parent perceptions of the program in which the child was involved.

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[1] Parents in Tasmania were not surveyed.

6.1.1
Children's Age, Sex and Disability and Family Size

Table 6.1

Age of children receiving services

Age range	N	%
0-1	62	9
1-2	144	21
2-3	168	24
3-4	136	20
4-5	112	16
5-6	50	7
>6	17	2
Total	689	

Of the 689 children surveyed, 378 were male (55 per cent) and 311 were female (45 per cent). The male/female ratio closely approximated that obtained from the program data. When the children were differentiated by age, it was found that 45 per cent (312) were aged between one and three years by comparison with 31 per cent in this age range in the program questionnaire data.

Parents were asked to state how many children in the family, including the child receiving the intervention program, were living at home. In 22 per cent (151) of families the disabled child was an only child. In 42 per cent (290) there were two children and in 21 per cent (147) there were three children living at home. The remainder consisted of families of four, 8 per cent (53), five, 4 per cent (26) and six, 1 per cent (10), children.

Table 6.2 categorises the children in terms of their primary disability as perceived by the parent. Some disabling conditions have been recoded to reduce the size of the table. Down's syndrome children, for example, have been recoded as primarily mentally retarded while cerebral palsied children have been recoded as primarily physically handicapped.

Table 6.2

Parental perceptions of primary disability

Disability	N	%
Mental retardation	336	49
Physical disability	113	16
Visual disability	44	6
Hearing disability	27	4
Multiple handicaps	90	13
Developmentally delayed	63	9
Behaviour problems	8	1
Unknown	8	1
Total	689	

6.1.2
Program Base

Programs have been classified under three different modes of provision: (a) centre-based programs, (b) home-based programs and (c) integrated or home- and centre-based programs. The parent was requested to identify the type of service provided and to supply details of the number of visits made to the home by the program staff or visits to the centre by the child. Twenty-seven per cent (184 children) received home-based services, 46 per cent (320 children) received centre-based services, and 24 per cent (165 children) both visited a centre and received regular home visits.

While these percentages were similar to the data from program questionnaires, there was some variation attributable to the higher proportion of children in this sample aged between one and three years. In this age group services are more likely to be home-based.

Tables 6.3 and 6.4 list the frequency of visits for home- and centre-based services respectively. Children receiving both types of service are included in each table.

Table 6.3

Frequency of home visits

Frequency	N		%
More than once a week	32		9
Weekly	67		19
Fortnightly	36}		10
Monthly	117}	72%	34
Less than once a month	97}		28
Total	349}		

Table 6.4

Frequency of centre visits

Frequency	N	%
Less than once a week	57	12
Once a week	168	35
Twice a week	172	35
Three times a week	88	18
More than three times a week	55	11
Total	540	

Of the 165 children receiving both services (integrated), 60 per cent (99) received monthly or less frequent home visits and 73 per cent (121) made weekly or more frequent centre visits. Only 52 children (32 per cent) received home visits more frequently than once a month and made visits to the centre weekly or more often.

6.1.3
Length of Time in the Program

Parents were asked to state the length of time their children had spent in the program (Table 6.5)

Table 6.5

Length of time enrolled in program

Months	N	%
<6	185	27
7-12	203	29
13-18	70	10
19-24	110	16
25-30	44	6
31-36	43	6
37-42	18	3
43-48	10	1
>48	6	1
Total	689	

While some parents provided dates of enrolment, usually the length of time spent in programs was reported in multiples of six, e.g., eighteen months, two years. The modal length of participation was twelve months (101 children). Table 6.6 relates the time spent in programs to the ages of the children.

Table 6.6

Length of time enrolled in program by age levels

(n = 618*)

Age (in years)	Time in program (in months)					
	<6	7-12	13-18	19-24	25-36	>36
0-1	40	22				
1-2	37	54	29	16		
2-3	34	42	22	29	33	
3-4	29	20	6	25	29	16
>4	27	26	12	37	17	16

*Owing to a peculiarity in the data collection, 71 cases from Queensland programs were not applicable.

6.1.4
Sources of Information concerning Program Availability

Over 80 per cent of parents (562) stated that the main source of information concerning the availability of the program in which their child participated had been a therapist, doctor, teacher or other professional. Thirteen per cent (90) learned about the program from a friend or relative, while 4 per cent (28) gained this information from different kinds of publicity.

6.1.5
Reasons for Participating in the Program

Respondents provided a wide spectrum of needs as the basis for their decision to participate in the program. Table 6.7 categorises these responses. The most frequently expressed need was the desire to provide opportunities for the handicapped child to develop, to train and to improve.

Table 6.7

Reason for child's participation

Primary reason	N	%
The best or only program available	165	25
To develop the child	396	60
To be able to attend regular school	66	10
Referred	33	5
Total	660	
Missing data	29	

The 165 parents who thought it was 'the best or only program available' were divided into two groups: the first with a choice of programs, the second with no other program options. For the first group, comprising approximately 100 parents, the program was the preferred choice for a variety of reasons which included convenience, home visits, small classes, and individualized programs. For the second group it was the only program available. Generally this group appeared to be more isolated: geographically, because of program logistics or by a particular disability that required unique care.

6.1.6
Helpfulness of Program for the Parent

Parents were asked if the program had helped them (as parents) in any way. The great majority of parents, 89 per cent (614) believed that the program had helped, while only a small minority, 4 per cent (26) considered that it had not been of assistance. Table 6.8 provides details of parental responses.

Table 6.8

Perceived helpfulness of program to parents

(n = 614*)

Types of help	N	Ranking
Helping the parent learn how to help the child	390	1
Helping to relieve some concerns	283	2
Helping the parent to get acquainted with other parents in similar situations	251	3
Helping the family to understand and deal with the child	129	4

*Multiple responses were applicable

6.1.7
Communication with Program Staff

Almost three quarters of all parents (491) were satisfied with program staff-parent communication. Of the 181 parents who wanted more frequent communication with staff, one quarter communicated less often than at monthly intervals. Table 6.9 indicates the frequency of communication between parents and program staff.

Table 6.9

Frequency of parent-program staff communication

Frequency	N		%
More than once a week	165		25
Weekly	246		37
Fortnightly	70		10
Monthly	107	39%	16
Less than once a month	85		13
Total	673		
Missing data	16		

6.1.10
Responsibility for Services

Replies to the question about responsibility for service provision showed that almost all parents (99 per cent) favoured some type of government agency. (Table 6.10)

Table 6.10

Parental beliefs about responsibility for service provision

Agency	N	%
Federal government	387	60
State government	210	33
Federal and state governments	18	3
Local government	21	3
Voluntary organizations	6	1
Total	642	
Missing data	47	

6.1.11
Parent Expectations of the Child's Educational Future

In order to examine parental expectations about their children's educational future, the parents were asked to indicate whether they regarded regular school or special school/classes as the most likely alternative. Two hundred and eighteen parents (35 per cent) believed that their children would attend regular school. The majority of parents (408), however, expected that their children would attend special schools or classes.

Parents were asked how they viewed their children's future, in general terms. Replies indicated a wide spectrum of hopes and fears concerning their welfare, ranging from very pessimistic expectations, through uncertainty to both realistic and unrealistic optimism. Thirty five percent (227) expressed hopefulness about continuing improvement in their children's life chances. Although data were not obtained on variations in parental perceptions of their children's future in terms of the type and severity of the child's disability, there can be little doubt that these factors exert a powerful influence.

6.1.8
Sources of Support, Encouragement and Help from Non-program-related People

Responses to the question concerning the sources of help, from people not normally involved in the provision of early intervention services for young disabled children, indicated that the most support was offered by spouses and relatives, followed by friends and neighbours. Clergy provided either a great deal of help or some help to a very small minority of the parents. This information is detailed in Table 6.11.

Table 6.11

Help from extra-program sources

Help from	Help								
	A great deal		Some		Little		None		
	N	%	N	%	N	%	N	%	(n)
Spouse	484	77	90	14	27	4	24	4	(625)
Friends	160	27	214	36	139	23	83	14	(596)
Relatives	256	42	174	23	106	17	76	12	(612)
Neighbours	61	11	108	20	135	25	234	43	(538)
Clergy	31	6	37	7	53	10	391	76	(512)

6.1.9
Other Programs serving the Child

For 387 parents (63 per cent) the only program assisting in the child's development was the one surveyed. One hundred and seventy nine parents (29 per cent) received services from one other program, 45 (7 per cent) from two other programs and seven children participated in three other programs. Sixty children (9 per cent) received services from two early intervention programs which provided complementary services, e.g., a home-based and a centre-based program.

The most frequently used alternative programs were of the playgroup, kindergarten, day-care type (132), with the child usually attending for one or two days a week. Of these parents, 92 (70 per cent) rated such programs as extremely helpful. The remaining programs comprised public and private medical and paramedical services, toy libraries, tertiary institutions, religious and social functions. In general, attendance occurred less frequently than weekly.

6.1.12

Program Evaluation

From the parents' perspective, program effectiveness was defined in terms of children's developmental outcomes. Responses described behavioural changes such as being toilet-trained, sitting up, talking more, exercising more independence.

The parents were asked about the program, the program staff, and associated support services. In response to a question: 'How helpful do you feel the program is for your child?' 461 parents (68 per cent) indicated that the program had been extremely helpful, 164 parents (24 per cent) thought that it had been fairly helpful, 45 thought that it had helped slightly and 5 parents thought that it had not helped at all. Fourteen parents did not reply, mainly because the child had not been in a program long enough for them to have formed an opinion.

When these responses were analyzed on the basis of children's ages, there appeared to be little variation in the perception of degrees of helpfulness for each age group, except in the case of children who were aged one year or younger. Seventy seven per cent of the parents of these children regarded the program as extremely helpful, 16 per cent fairly helpful, and 7 per cent slightly helpful.

Responses were also analyzed on the basis of the length of time spent in the program. Seventy six per cent of parents whose children had been in the program for more than one year viewed the program as extremely helpful, 19 per cent fairly helpful and 5 per cent slightly helpful. In the case of children who had been in programs for twelve months or less, 378, 64 per cent considered the program extremely helpful, 26 per cent fairly helpful, 8 per cent slightly helpful, and 5 parents thought it had not helped. As this group included children aged twelve months or less, those parents have considerably lower opinions of the programs.

Parents involved in the various programs differed considerably in their perception of the program's usefulness. Of the 22 programs reviewed four were rated by 90 per cent of parents as extremely useful; seven attracted this response from 70 to 90 per cent of parents, while the remaining 11 were rated in this category by only 49 to 69 per cent of the parents. Six programs were excluded from this analysis because of the low rate of parental response.

Since entering the program, 568 parents (89 per cent) had noticed changes in the behaviour or activities of their children at home, while 69 parents considered that there had been no noticeable change. Of those who noticed changes, 344 (61 per cent) had noticed many changes, but 224 (39 per cent) only a few. Fifty two parents did not respond, some because the child had been in the program for only a short period. Fifteen parents had noticed regressive changes.

There was little variation in these proportions when responses were analyzed according to the children's ages. Of the parents whose children had been in the program for six months or less, however, 42 per cent had noticed many changes and 19 per cent had not, as opposed to 68 and 7 per cent respectively for the total sample. These percentages remained constant across different programs. The behavioural changes noted after the child's entry to the program are set out in Table 6.12.

Table 6.12

Behavioural changes noted after entry to program

Area of change	N	%
Overall	143	27
Social/self help skills	146	28
Language	46	9
Visual	15	3
Fine motor	11	2
Gross motor	45	9
Milestones attained	39	7
Awareness	78	15
Total	523	
Missing data	166	

Parents were asked if they thought the program serving their children might be expanded or improved. While 48 parents did not answer the question, 433 parents (68 per cent) thought the program could be improved or expanded.

As the length of time spent in the programs increased, so did the proportion of parents who thought the program could be changed. The number of parents who considered that change was needed ranged from 59 per cent of those whose children had been in programs for six months or less to 77 per cent of those whose children had been in the programs for two or more years.

Table 6.13 presents parental evaluation of sources of support, encouragement and help from those usually associated with early intervention programs. The evaluation of program staff was the only source of substantial variation across different programs. In general, the variations across programs were similar to those reported earlier on the parental evaluation of the helpfulness of the program.

Parent ratings of the help given by doctors decreased as the age of the children increased. Almost 40 per cent of parents of children aged one year or younger thought doctors had helped a great deal, whereas only 18 per cent of parents of children older than three years held this view. Correspondingly, the number of parents who thought doctors were of no help rose from 15 per cent of children aged one year or younger to 28 per cent of parents with children older than three.

Table 6.13

Help from program and associated sources

Help from	Help								
	A great deal		Some		Little		None		
	N	%	N	%	N	%	N	%	(n)
Program staff	459	73	110	18	42	7	14	2	(625)
Doctors	136	25	147	27	136	25	135	24	(554)
Other professionals	97	21	107	23	66	4	201	43	(471)
Other parents of children with disabilities	111	20	143	26	116	21	183	33	(553)

6.1.13

Perceived Needs and Major Areas of Concern

To the question, 'What help do you need or want that you are not receiving?' 474 parents (68 per cent) provided a wide spectrum of unmet needs. These needs, too numerous to list separately, have been classified under several headings: therapy services, information about services, help on how to cope, home help and child care. The distribution of needs is set out in Table 6.14. By far the most frequently expressed need was for therapy services. Of the 164 parents who wanted therapy services, 118 specifically mentioned speech therapy.

This question was not answered by 215 parents. Either this substantial number of parents were securing all the assistance that they required, or were unable to specify their unmet needs.

Table 6.14

Areas of unmet need

Types of need	N	%
Therapy services	164	35
Information on services	114	24
Help on how to cope	103	22
Home help	75	16
Child care	18	4
Total	474	
Missing data	215	

Parents were also asked to indicate their major worries about the children. Table 6.15 sets out the major areas of parental concern.

Table 6.15

Major areas of parental concern

Area	N	%
Child's development	208	33
Future	176	28
Coping	113	18
Dependence of children on family	69	11
The need for continuing support	63	10
Total	631	

Four questions, both the two preceding items and two others, also asked the parents to comment freely on (1) concerns and feelings not covered by the questionnaire and (2) possible expansion and improvement of existing programs. Since the wide variety of parental concerns and suggestions for improvement could not be classified in tabular form a sample of these responses is included in Appendix D.

However, comments in those four items which referred to programs and which expanded the other data obtained, were coded around a particular locus of concern, and ranked in order of frequency. These areas of concern are set out in Table 6.16.

Table 6.16

Areas of major parental concern

Issue	No. of Parents	Ranking
Responsiveness to the needs of families with young handicapped children	82	1
Lack of public awareness of how to identify children's special needs and seek appropriate services	51	2
Rationale of programs (e.g. acceleration of child's development in one or more specific skill areas focal to the handicapping condition, fostering of all aspects of the child's development, and/or provision of family support)	44	3
The logistics of the program (e.g. transport, timetables, distance)	43	4
Sources and adequacy of funding	39	5
Parameters of programs (e.g. integration of handicapped with non-handicapped children, program provision for children with varying handicaps, provision limited to children with one specific handicap)	37	6
Staffing of programs	36	7
The roles of family members in programs	28	8
Communication between early intervention program personnel and relevant services for the community at large	23	9
Relationship between early intervention programs and the wider network of special services for handicapped children	19	10
Responsibility for the future provision of early intervention services	11	-
Monitoring and evaluation of programs	4	-
Total	417	

6.2

WORKSHOP DISCUSSIONS

Workshops were conducted in all capital cities for parents of children receiving early intervention services.

These workshops were designed to serve a number of purposes:

- to provide opportunities for parents of young handicapped children to discuss with academic and research staff both their own and their children's needs, and to identify areas of major concern;

- to comment on the adequacy of existing diagnostic and treatment facilities and support systems, and to identify major inadequacies in the provision of services;

- to make suggestions concerning changes to and expansion of existing services which would best satisfy unmet needs.

Review and analysis of parents' contributions to the group discussions, which were an important component of the workshops, confirmed that the major concerns expressed in these sessions reflected the findings observed from data supplied by the parent questionnaires, namely

- the need for responsiveness, at community and professional levels, to the needs of parents and their handicapped young children;

- the need for increased community awareness of the nature of disabilities and their impact on both the handicapped child and his family.

The overwhelming impression gained from participation in the parent discussion groups was the feeling of isolation experienced by many of the parents, and particularly the mothers, of disabled infants and young children. Parents were deeply concerned by the fear, ignorance, prejudice and rejection which they encountered in the general community. If the measure of a civilized society is its tolerance of deviance and its recognition of the obligation to protect and nurture its weakest members, then contemporary society appears to fall far short of this ideal.

Many parents reported that the most helpful and realistic support they received was the understanding and experience of other parents of handicapped children.

Increasing community awareness of the nature of disabilities and their impact on the child and his family was given urgent priority by the parents. Recognition that the disabled child has the same right to grow and develop to the limits of his potential as have his non-handicapped peers should ensure the provision of a comprehensive network of diagnostic and treatment facilities, as well as family support services aimed at maintaining the child within the community.

Parents stressed their right to be given, jointly and as soon as possible after birth, honest information concerning the nature of their child's disability, the implications for his future development and concrete strategies for coping with his special needs. Parents acknowledged that they experienced emotional reactions such as shock, guilt, shame, chronic sorrow, even rejection and denial which required sensitive understanding from the professional workers with whom they came in contact during this period. They emphasized, however, that these reactions were normal responses to extreme stress, and not evidence of a neurotic personality. They welcomed counselling only when it was reality-based and oriented towards giving them the problem-solving skills to cope more effectively with the stresses that the advent of a handicapped child placed upon interpersonal relationships within the family and on the family's total functioning. They argued that the physical and emotional exhaustion experienced by the mother in caring for a handicapped infant made it imperative for respite relief to be readily available.

Parents stressed their right to a more collaborative role with the professionals involved in their child's care and treatment. They pointed out that their close continuous relationship with the child meant that they were the ones with the most detailed and intimate knowledge of the child's abilities and weaknesses and that this knowledge should be included in assessment of the child's developmental status. They argued their right of access to medical and other records detailing the nature of the child's disability and changes in his growth and development.

During the child's pre-school years, many of the parents' concerns were related to the availability and adequacy of intervention services. Parents stressed the need for both diagnostic and treatment services to be co-ordinated, preferably at a centrally located and easily accessible site. They considered that co-ordination of services would help obviate the many referrals and long intervals between appointments which several had experienced. Access to therapy and treatment programs often involved lengthy delays, which needed to be eliminated. Support systems aimed at maintaining the integrity of the family, and giving periodic relief from the exceedingly heavy responsibilities of parental care of a disabled infant or young child, were seen as an essential need. These services included: babysitting at short notice by a competent person, access to day care, and short term care to allow time for other family duties and responsibilities to be attended to. Because of geographic mobility many families in Australia are isolated from their kinship group, particularly grandparents who have traditionally been the source of respite and relief for over-burdened parents.

It was suggested that one possible solution to this problem was a training program for 'surrogate' parents which would give them understanding of the child's problem and the skill to care for him for short periods, without the formality or long-term implications of foster care. A program such as this seems especially important for areas such as the Northern Territory; a substantial proportion of the population of this area has moved from other localities, thus reducing or curtailing parent and family contacts.

Caring for a handicapped child at home involves families in both obvious and hidden expenses. Existing sources of financial assistance need to be publicized. A surprising number of parents at the workshops disclosed that some time had elapsed before they had learned about the Handicapped Children's Allowance. Parents considered that more financial help was needed, and that there should be more flexibility in the use of available funds.

Various approaches to increasing public awareness and understanding of disability were suggested during the workshop discussions. The groups felt this awareness should include knowledge of the kinds of services available in the community, the functions they perform, and how contact may be made with them.

1. It was suggested, many times, that more use could be made of the popular media - television, radio, newspapers and magazines - which should assume greater responsibility for educating the community about the nature of disabilities, their impact on the child and his family, and their implications for the community. In particular, the right of disabled children to have access to community facilities needs to be stressed. Special provisions and services to accommodate these children's special needs and those of their families should be advocated as a right of this vulnerable sub-group and should be an obligation recognized by the general community. It was acknowledged that several excellent programs had achieved some measure of increased awareness but that a great deal of work remained to be done. Parent organizations could make an important contribution to the encouragement of media attention by working with programs, agencies and departments to

- write letters of commendation or telephone approval of worthy efforts,
- make suggestions for desirable activities, offering assistance,

- criticize sharply any negative images portrayed.

2. It was recognized that, although directories of services have disadvantages, especially the speed with which they become out of date, particularly at a time when services are expanding rapidly, they do perform several valuable functions

- suggesting to parents the range of services available,

- creating awareness of future as well as current options,

- informing general practitioners, paediatricians, hospitals, agencies of maternal and child health and welfare and other community services of available services for the handicapped.

Compilation of directories can be expensive and their effective use depends upon careful dissemination. Easy and widespread accessibility is important. Libraries, for instance, would be suitable locations for their display as would toy libraries for both the non-handicapped and the handicapped.

3. It was suggested that a central non-aligned agency, with a widely publicized telephone number, could serve as an initial contact for parents concerned about their children's development. This agency could act in a referral capacity, directing parents to appropriate assessment, diagnostic and service facilities. This information would also be of assistance to professionals and community services that might make contact with 'at risk' and handicapped children.

4. Parents endorsed recent initiatives such as the integration of handicapped youngsters in regular settings and the application of the principle of normalization in the provision of services. One example was fostering of handicapped children as a preferred alternative to institutilization. These initiatives should make an important contribution to educating the wider community, and parents underlined their importance.

5. Co-operative employers and work environments which recognize the role of parenting and provide flexibility to enable parents to perform this role adequately for a child with special needs make an important contribution.

6. Parents themselves can be a primary source of information to the public. Open demonstration of their love for and pride in a disabled child can be an important source of attitude change in others, particularly those who have had no first-hand experience of handicap.

7. Professionals and para-professionals who service the community at large, particularly doctors, nurses and teachers, should all have training that incorporates understanding of the nature of handicap.

Many of the urgent and continuing concerns expressed by parents, and described in the preceding section, reiterated the themes of the conference convened by the National Women's Advisory Council for mothers who had given birth to disabled children.

While this Conference, held in Brisbane in May 1980, addressed itself to the needs of handicapped children and their parents throughout the whole of childhood and beyond, many of the recommendations contained in its report "My child was born disabled..." refer specifically to the needs of handicapped infants and young children and their families, including the provision of early intervention programs.

CHAPTER 7

PLAY AND THE HANDICAPPED CHILD : TWO PILOT STUDIES WITH DEVELOPMENTALLY DELAYED CHILDREN

P.Gunn

Play in childhood provides a means of discovering and rehearsing skills which promote the growth and competency of the child's ability to manipulate his real life environment.

Most children learn to play - and play to learn - with the relaxed, untutored help of significant others (parents, siblings, peers). Handicapped children are at risk of meeting barriers in their play development that cannot be removed without some knowledge of the appropriate, structured assistance necessary to help them.

Insights into the play needs of handicapped children are most likely to flow from intensive longitudinal studies. The first study described in this chapter was longitudinal but necessarily involved a limited period of time. A Down's syndrome child was observed at monthly intervals between the ages of 5 months and thirteen months and again at fifteen months. The purpose of the study was to observe mother-child interaction in terms of tactile, kinesthetic, visual and vocal play. The second study involved eight children with developmental disabilities who were observed in two settings: a special pre-school for handicapped children and a regular pre-school or kindergarten. The examination of the use of play materials, play relationships and vocalizations has implications for play in early intervention programs.

7.1
INTRODUCTION

It is widely acknowledged that the handicapped child is dependent on others for a longer period than is his non-handicapped peer. In addition to this longer dependence, the type of handicap, its severity, its duration (whether it is temporary or permanent), the age of onset and the prognosis are all factors which influence the child's development. The effect on development, however, is not restricted to the domain of the handicap. For instance, if the infant's nonvisual (Fraiberg, 1979) or nonhearing vocabulary is not recognized, a sensory handicap may lead to emotional impairment. In the case of physical handicap, if the opportunity for motor play is limited, the course of social and emotional development as well as physical development will be affected. Through motor play with his body, the infant develops body-awareness and a sense of his own capabilities. He learns to master his body and to explore the environment. When motor play and exploration are restricted, knowledge of the wider world, its objects and persons, is also restricted. As a result the handicapped child may have difficulties in the development of autonomy and possibly of attachment as well. This link between emotional development and physical or sensory handicap is sometimes overlooked (Murdoch, 1979).

Since the handicapped infant is dependent on the intervention of care-givers for a longer period and in more circumstances than the child without handicap, there is a greater risk that in his case play will be viewed from an instrumental framework rather than as an internal dimension of his behaviour. The situation in which the child is playing and the materials provided for play may have to be structured to meet his unique needs, and the specialist literature and toy libraries have many suggestions for specific handicaps (Finnie, 1974; Freeman, 1970; Lear, 1977; Mogford, 1977; Newson, Newson, Head & Mogford, 1976). Some handicapped children may even have to be taught how to play with playthings (Wehman, 1979), but if the children can play only under supervision, that teaching must be regarded as ineffective.

If play is seen as a desirable behaviour, the aim should be to "generalize" it to a wide range of contexts. The child must be able to play independently and to gain the feelings of satisfaction and mastery which are relevant to the internal dimension of play.

With regard to these feelings of satisfaction, it should also be kept in mind that the child may need to be diverted from acting only for the pleasure of receiving a social reward. There is sometimes a danger in structured play intervention that the handicapped child gets pleasure from adults' "good boy" or "good girl" rather than pleasure or meaning from his own behaviour. This will detract from his ability to play when alone or with peers.

The importance of structuring the setting and the playthings to meet the individual requirements of the handicapped child is readily acknowledged but the need to encourage social play with peers is sometimes forgotten. Yet the importance of such play to children's development has been widely acknowledged.

> Current evidence shows that, without an opportunity to interact with other children, children have difficulty in learning effective communication skills, modulating aggressive feelings, accommodating to social demands for appropriate sexual behaviour and forming a coherent set of moral values. Peer relations are not luxuries in human development; they are necessities. (Hartup, 1978; p.28)

The development of social play proceeds from a setting in which an adult sets the context for conjoint action to one in which play with peers assumes a greater role. Until agreement is reached on the rules of interchange, social play with peers may be expected to have unpredictable aspects for the participants. When a child is playing with a caregiver, the latter may deviate only slightly from well rehearsed routines but deviations may well be considerable during the child's initial encounters with peers. The ability of a handicapped child to tolerate this loss of predictability or to moderate it by negotiating acceptable rules of interaction will influence the course of his social play with other children.

Co-operative sharing, turn-taking and games may be especially sensitive to the effects of handicap, particularly if language is impaired since this will restrict the child's access both to specified rules and to agreement on the terms of exchange. Adults may play a crucial role in teaching both social rules and the rules of specific games. Caregivers may need to determine when ritualized sequences or games with rules can most appropriately be taught to the handicapped child, both with regard to his own skill and pleasure and also with regard to the possibility of their use later during play with others.

It is often suggested that the early exchanges between a mother and her infant set the foundation for the child's knowledge of turn-taking and other social rules. Stern (1977) has suggested that motoric play has a special role to fulfil in these exchanges since it serves to keep the infant at an arousal level which is optimal for attention to the mother's signals. When Crawley *et al.* (1978) studied changes in mother-infant play at 4, 6 and 8 months, they also concluded that maternal behaviour is geared towards getting an optimal level of infant participation. In addition, however, they pointed out that this participation is constrained by factors which relate to the infant's developmental level. Play with the 4 month old infants, for example, did not require motoric skill on the infant's part and there was a trend towards conventional motoric role games with age. Other researchers (Gustafson, Green and West, 1980; Bruner and Sherwood, 1976; Kleeman, 1973) have documented the way in which the infant's role in these games becomes a more active engagement by the end of the first year of life.

Handicapped children have not been included among the subjects in studies such as those reported above where developmental changes in mother-infant play have been researched. It would be reasonable to anticipate that the structure of games played would be constrained by the infant's developmental level; but it would be of considerable interest to examine whether there is also a trend towards conventional motor games as the age of the handicapped child increases.

7.2
PILOT STUDY OF MOTHER-INFANT PLAY

To provide information on such issues, a longitudinal pilot study was undertaken of the characteristics of mother-infant play with a Down syndrome infant who was developmentally delayed. This boy's scores on the Bayley Scales of Infant Development at 12 months yielded a Mental Development Index of 58 and a Psychomotor Development Index of 50. He had no sensory impairment but his motor development was delayed. He did not sit alone until 10 months or crawl until 14 months of age.

A number of sessions in which the child was playing with his mother were recorded and analysed according to the Crawley et al. (1978) categories for games.

1. tactile
2. gross body movements - mother moves infant's body in space
3. limb movement - mother moves infant's limbs in space, either
   3a. non-motoric role, or
   3b. conventional motoric role
4. visual - mother provides stimulation that may be visually observed by infant, either
   4a. non-motoric role, or
   4b. conventional motoric role.

Conventional motoric role games include such games as pat-a-cake, peek-a-boo, waving bye-bye. If the mother demonstrates these games visually they are classified as 4b. If she moves the infant's limbs to demonstrate the game, they are classified as 3b.

Non-conventional games lack a traditional role and appear to be directed at arousing the infant or maintaining his attention.

For the present study it was also found necessary to add an extra category of game. This was vocal play which was coded when the mother vocalized to the infant in a playful, repetitive manner, face-to-face. The sensory input depended mainly on the sound pattern of vocalization. Apart from an occasional kiss, there was no tactile or kinesthetic play and the visual input depended on the mother's facial expressions. During the period studied, these vocalizations tended to be non-conventional sounds, e.g. raspberries, cooing, or da-da and ma-ma syllables.

During the play sessions, the mother sat in an arm chair with the infant on her knee but she was free to move about (and move the infant) as she pleased.

Table 7.1 shows the proportion of playtime which was spent in either tactile or kinesthetic play. This appears to agree with the finding of the Crawley et al.(1978) study by demonstrating a clear reduction in tactile stimulation with age. In the last two play sessions in our study, however, the mother demonstrated "Round and Round the Garden" and "This Little Piggy" on the child's hands. These were classified as conventional games under the visual category but they do have a strong tactile component. Perhaps another category of conventional games is needed here.

Table 7.1
Tactile and kinesthetic play as proportion of playtime
Down's syndrome infant

Chronological age (months)	Category of play Tactile	Whole body movement	Limb movement non-motoric	 conventional
5	.27	.36		
6	.14		.38	
7	.21	.30		.03
8	.20	.32		.06
9	.21	.45		
10	.24			
11	.18	.06		
12	.07	.34		
13	.03			.43
15	.00	.04		.27

The high proportion of whole body play is probably a better naturalistic guide than the Crawley *et al.* study which showed few games in this category. This, however, appears to be an artefact of their experimental setting where the mother sat on a stool facing her infant who was in a port-a-crib; by contrast, in our study, as indicated above, the mother had freedom to move herself and the infant. The marked increase in limb movement games which have a conventional motoric role at 13 months is paralleled by a similar change in the visual play. The changing nature of the visual stimulation offered by the mother is shown in Table 7.2 which gives the proportion of playtime which was spent in either visual or vocal play. Visual stimulation changed from an attention getting role at 6 months, and the "I see" or "Peek-a-Boo" game was introduced at following sessions. However, when the child was able to sit up and move with more confidence at 10 months, the mother again introduced visual stimulation to attract and maintain his attention. As her use of visual stimulation for play decreased, she appeared to increase her use of vocal play. This, too, was related to the child's development since much of this play consisted of the mother's imitation of the child's vocalizations.

Table 7.2
Visual play and vocal play as proportion of playtime
Down's syndrome infant

Chronological age (months)	Category of play Visual non-motoric	Visual conventional	Vocal
5	.31		.06
6	.40	.08	
7	.07	.12	.28
8		.22	.19
9		.12	.21
10	.31		.44
11			.75
12	.01	.02	.54
13		.34	.21
15		.34	.34

These observations have shown that by the time this child was 13 months of age, his mother spent a high proportion of the play session in demonstrating conventional games to him. The study has also shown that vocal play was common after 6 months of age, that the "Peek-a-Boo" game was played with the mother as agent in the second half, and that the child imitated a whole body game when 12 months of age. At this session he vocalized "uh" and his mother played an "up-down" lifting game with him. This was repeated several times.

It is not suggested that the development of the games within this dyad is representative of all such dyads; for instance the proportion of vocal play may reflect social class or cultural factors. The account does, however, illustrate some changes in the structure of mother-child play which depend on various aspects of the child's development. It also illustrates the way in which the play changes during infancy from arousal or attention getting towards conventional games in which the infant will later take a more active role.

When the infant takes part in these conventional games, it may not be the content of each individual game which is important but rather the shared pleasure and the structure which are common to most games. That is, there is a definite beginning and end with pauses which allow for turn-taking, and the total sequence is ritualized with well defined responses. Perhaps even more important is the high peak of interest, attention and positive affect which are all conducive to learning and which are all characteristics of the internal dimension of play.

7.3

PILOT STUDY OF THE PLAY OF HANDICAPPED PRE-SCHOOLERS

The infant's introduction to games and the rules of social exchange usually takes place during interactions with caregivers and knowledge of these rules (e.g. turn-taking and sharing) is later put to the test during encounters with others. Interactions with other children are especially important as the child grows older and such interactions are influenced by the child's level of social and communicative skill and are also contributors to the development of these skills.

It is recognised that interaction with peers is important for handicapped as well as for non-handicapped children and there is currently much interest in the possible benefits of interaction between children of different developmental levels. It has been suggested that the development of less advanced children may be enhanced by the availability of more competent models while the more advanced children may become more sensitive to individual differences (Guralnick, 1978).

Although these benefits have been proposed for the integration of handicapped and non-handicapped pre-school children, studies to date have given equivocal results. These studies, however, have been largely confined to American settings and the majority have been concerned with groups which had a high proportion of handicapped children. In those Australian cities in which enrolment in pre-schools and kindergartens is readily available, handicapped pre-schoolers are likely to be a minority in an integrated setting and the American data may be inappropriate.

For the present pilot study, eight children (4 boys and 4 girls) who attended both a special pre-school for handicapped children and a regular kindergarten or pre-school were observed playing in the two settings. The children attended four different special schools and eight different regular schools, all within the greater Brisbane area. In each regular setting, the sample child was considered as the only one whose handicap was severe enough to need the extra attention in the special setting. All the children were developmentally delayed (although the delays were of varied etiology) and all were mobile. Their chronological ages ranged from 4 years to 6 years but on a Reynell language assessment, two children scored below 3 years on the verbal comprehension scale and five scored below 3 years for expressive language.

A play session was video-recorded for each child in each setting with subsequent coding according to the Tizard, Philps and Plewis (1976) modification of the Parten (1933) categories of social play. The play was also coded for the Tizard *et al.* categories for the use of play materials (partial, appropriate and symbolic), and for the number of remarks initiated either by the study child or by an adult to that child.

Preliminary results for 30 minutes play in each setting (Table 7.3) indicate that -

- there are more adult directed interactions in special units than in regular groups
- there are more adult-child interactions than child-child interactions in both settings

- there is more solitary and parallel play than social play in both settings with a trend towards more social play in the regular setting
- more play is appropriate rather than symbolic in both settings.

Table 7.3

Child's behaviour in different settings
Brisbane & British studies

	Brisbane Study		Tizard *et al.* (1976) Mean	
	Special Unit Mean	Regular Group Mean	(CA 4 yrs)	(CA 3 yrs)
Percent play which is:				
partial	20	20	22	31
appropriate	74	76	41	41
symbolic	4	3	33	25
parallel or solitary	92	86	57	69
social	8	13	43*	31*
In 30 minutes, remarks				
initiated to another child	3	3	41	28
initiated to an adult	8	4	8	6
initiated by an adult to this child	25	10	9	9

* estimated from published data.

Most symbolic play in both settings involved family role themes, usually cooking, shopping or putting the baby to sleep. In the special units it was usually initiated and sustained under adult direction, but in the regular setting the pretense play was more often initiated by another child than by the teacher. The very low frequency of pretense play as compared with the Tizard *et al.*(1976) results for non-handicapped 4 year old pre-schoolers may be related to language delay but it also suggests that adults may need to play a greater role than they do in encouraging these children towards fantasy play. In the regular settings, the other children often provided imaginative models but the handicapped child was often not exposed to these. He could, instead, be found at an activity such as threading beads or completing one jigsaw after another.

At least one teacher in the regular setting was already taking steps to encourage the handicapped pre-schooler in her group to play with more than jigsaws (or form boards). Another developmentally delayed boy was seen to complete the same puzzle six times in the one regular play session yet he did not show the same perseverance in other play areas. Perhaps the attraction of these puzzles is the child's ability to reach a successful conclusion. Or perhaps the task shelters the child from a more threatening social activity. Whatever the reason, adult intervention seems to be necessary if these children are not to stay at the puzzle table for very long periods.

Since the children showed varying degrees of language delay, it is not surprising that the mean number of remarks to other children was considerably lower than that reported by Tizard *et al.* for normal 4 year old pre-schoolers. It is reassuring, however, that social play was not inhibited but was often marked by smiles and actions rather than by words.

This study is limited by the small sample size and by the duration of the coded playtime. It does suggest, however, that teachers of handicapped pre-schoolers may need to play a greater role in encouraging pro-social behaviour. At present this seems mainly to be left to song turn-taking sessions. Perhaps there is too much emphasis on the materials for play and the cognitive and physical aspects of the children's development rather than on their social needs. There is always a risk that in focussing on the handicap and the program to remediate it, other aspects of the child's development are neglected. This pilot study may serve some purpose in drawing attention to the symbolic and social aspects of the handicapped pre-schooler's play development.

The development of early intervention programs is currently occurring in a context of limited knowledge of the course of development of young handicapped children. Child development has emerged as a major research area, uniting interests that have in the past been studied in isolation within a number of separate disciplines. Concerted research efforts have been directed to producing holistic theories describing and seeking to explain the usual course of human development. It is only recently that a similar effort has been extended to consideration of exceptional development. The studies completed at the Schonell Educational Research Centre have been framed within the perspective of the search for an holistic theory of exceptional development which might guide the design of early intervention programs

The reader is directed to Appendix K for a listing of such studies which have been completed at this Centre.

CHAPTER 8

TOY LIBRARIES AND EARLY INTERVENTION

J.Elkins

The study of toy libraries formed an integral part of the wider study of early intervention programs in Australia. Toy libraries are not, of course, primarily early intervention programs although they may provide some components of early intervention services. More frequently, they may serve as an additional resource for early intervention programs offered by other agencies. The relationship of toy libraries to early intervention programs is shown in the diagram of services to the entire community (Figure 8.1).

Some toy libraries may be very closely associated with early intervention programs. Other toy libraries may supplement programs provided by other services for handicapped people of various ages. There are also toy libraries, outside the scope of this study, providing services to non-handicapped people. Some toy libraries, of course, may combine aspects of these three major types.

The study has entailed extensive interaction with toy library personnel. Detailed questionnaires were completed by the staff of toy libraries, and for a sample of toy libraries questionnaires were distributed to parents. The full report on toy libraries, of which the following is a condensed version, was published by Elkins et al. in 1980.

8.1
INTRODUCTION

Two criteria were used in determining which toy libraries would be the focus of this study: first, toy libraries were included if they offered services to handicapped children; and second, toys must be made available to be taken away from the library premises, i.e. a toy lending service existed. A few toy libraries were included although they did not meet neatly the two criteria for inclusion. For example, the Kath Dickson Centre Toy Library caters for the handicapped and non-handicapped, but it has a specific core group of toys for the handicapped. The Sydney Teachers' College Toy Library serves non-handicapped children in the immediate vicinity as well as children with special learning needs. However it gives only a minimal service to local non-handicapped children.

The questionnaire for toy libraries was prepared in consultation with the Australian Association of Toy Libraries for the Handicapped, members of which reviewed a draft and made numerous suggestions to facilitate obtaining accurate and full information. The purpose of this questionnaire was to permit a detailed description of several aspects of toy library services: (a) the kinds of services offered; (b) the clientele served; (c) the toy library's relationship with the community (including relationship through referral and liaison); (d) the facilities available; (e) the extent of toy library use in terms of numbers of clients and resources; (f) toy library procedures and ways of informing the public of their services; (g) staff members and their characteristics; (h) organization and planning; (i) funding sources and policies; and (j) needs assessment. Toy libraries were also asked to identify problems and areas of concern.

The parent questionnaires were designed to elicit information on (a) the characteristics of the child using the toy library (age, disability); (b) other special services available to and used by the family; (c) the perceived usefulness of the toy library; and (d) expressions of need for additional services to the child and family.

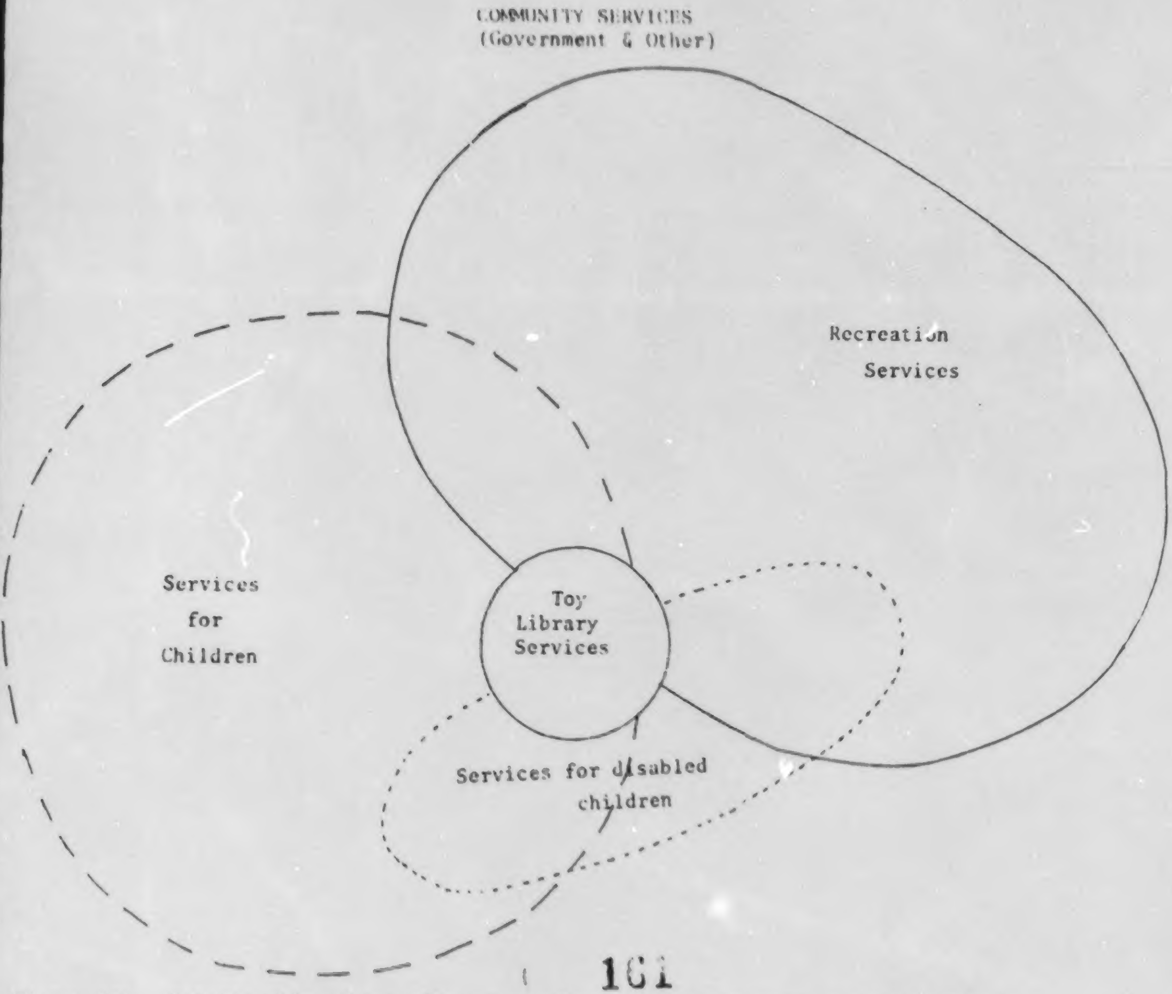
COMMUNITY SERVICES
(Government & Other)
Recreation Services
Services for Children
Toy Library Services
Services for disabled children

Figure 8.1 Relationship of toy library services to other relevant community services.

8.2
THE TOY LIBRARY MOVEMENT

Recognition of the importance of play for learning, particularly for children with disabilities, has led to the development of special toy libraries for children with special needs. According to Forell (1973), toy libraries for children with specific disabilities were developed in Sweden in 1963 and, by 1974, there were about 50 toy libraries in Sweden. By 1977, there were 350 toy libraries in England (Newson, Newson, Head and Mogford, n.d., p.67), and the first international conference of toy libraries was held in 1978.

A proposal that toy libraries be an extension of existing pre-school services was made within the past five years by E. Borsboom in "Early Childhood Resource Book No. 2" published by Dept. of Education (Q).Some private agencies have also attempted centralized planning of toy libraries. The New South Wales Society for Crippled Children has established five toy libraries at various facilities. The Kindergarten Union of South Australia has provided a centralized toy library service for handicapped children.

The Family and Children's Services Agency of the New South Wales Department of Youth and Community Services has guidelines for funding toy libraries. However, these guidelines imply an existing policy only for the establishment of toy libraries and other services, but for their continued support. They also imply the establishment of toy libraries for a cross-section of the community, or for a combination of disadvantaged groups, rather than for the handicapped only.

Examples of co-ordination of services at a local level can be found also. The formation of the Gold Coast City Council Toy Library was discussed by an "informal committee ... consisting of representatives from the various services catering to handicapped children in the city". * Noah's Ark Toy Library for Handicapped Children at Bendigo resulted from efforts of "a group of people professionally involved with handicapped people at Bendigo". In N.S.W., co-ordinators of the Handicapped Persons' Bureau of the Department of Youth and Community Services encourage the development of local groups of representatives of services to the handicapped, to foster co-operation and shared planning efforts that can have implications for all services to the handicapped.

Information concerning toy libraries for the handicapped in Australia suggests that developments in England exerted a significant influence on the toy library movement in this country. For example, even where cataloguing methods are concerned, the majority of toy libraries responding to questionnaires for the present study use the English Toy Libraries Association publication "ABC of Toys". The two major influences appear to have been the Nottingham University Toy Library and the Toy Libraries Association of England.

The purpose and essential functions of the Nottingham Toy Library - toy lending and guidance for parents of children with any handicap - are echoed in Australian toy libraries. The use of client appointments at regular intervals, typical of other European toy libraries, is also matched by some Australian toy libraries.

Visits to the Nottingham Toy Library preceded the establishment of the Melbourne Noah's Ark Toy Library in 1971. The activities of the Noah's Ark Toy Library influenced the concept of toy libraries elsewhere in Australia and resulted in dissemination of information concerning English and other European

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* Quotations appearing without source references are from information supplied by Program Directors in the returned questionnaires or relevant leaflets.

developments. Other influential toy libraries were the Torrens CAE Toy Library and Parent Advisory Centre and the Special Education Resource Unit in South Australia, both of which opened in 1974. These two toy libraries co-operated to produce a handbook "Developing Special Education Resource Units and Toy Libraries" published in 1976. The Colony 47 "Toy Town" and the Noah's Ark Centre in Canberra also played an important role in the toy library movement in Australia. Along with the Melbourne Noah's Ark, these four toy libraries were instrumental in establishing the Australian Association of Toy Libraries for the Handicapped (AATLH).

Among the aims of the AATLH are:

1. To establish an effective communication network between Toy Libraries for the Handicapped throughout Australia and members of the AATLH.

2. To further the setting up of Toy Libraries for the handicapped whose purposes shall be -

   to assist the development from the earliest stage of all handicapped persons whatever their disability;

   to provide family resource centres and professional advisory services for the handicapped and their families;

   to make available a wide range of appropriate toys and equipment; and

   to foster the understanding of the need for play and recreation in the development of the handicapped person.

3. To promote, work for and maintain communication between AATLH and -

   - individual toy libraries;
   - other professional persons and organizations;
   - manufacturers, designers and other interested bodies;
   - societies for handicapped persons;
   - Government agencies;
   - any other interested body and/or person.

4. To facilitate seminars and conferences in order to further knowledge and understanding of the aims of AATLH.

5. To foster appropriate research and publications.

8.3
POTENTIAL ROLES FOR TOY LIBRARIES

Services which enable parents of young handicapped children to borrow toys at a minimal cost are a necessary component of overall family support. There is a clear analogy with book lending services implicit in the name "toy library". It would appear that several factors which influence societal support for book libraries apply to toy lending also. Both books and toys represent substantial purchase costs, for toys ranging from $5 to many tens of dollars, with an average cost in the $15 - $25 range. Parents of handicapped children already face extra costs in many aspects of their parental responsibilities. Government programs act to minimize the impact of such extra costs, for example, through the handicapped children's allowance for which some are eligible. Parents also experience selection difficulties when attempting to purchase toys for children, especially the very young. Where handicap makes development slow or atypical, parents may need additional assistance with toy selection.

Parents and siblings of young handicapped children often have unmet needs which can at times place great stress upon the family unit. Furthermore, because of the history of devaluation and stigma associated with services to the handicapped in Australia, there are very real impediments to the alignment with appropriate services of families having young handicapped children. There is a clear need for non-threatening and readily accessible centres where parents can find assistance, advice and acceptance as they adjust to the implications of parenting a handicapped baby or toddler and come to understand the options available to assist them in providing for the needs of the handicapped child and of the total family unit. There is increasing evidence that a transactional model, which addresses the needs of family and wider community, has advantages over one which focuses only on the deviant child.

Parents of a handicapped child often feel isolated and devoid of assistance even though services may exist in their local community. This may be especially true in those doubting times when a diagnosis of handicap has not yet been made. The reduction of support, provided in earlier decades by the extended family, exacerbates the extent of their feeling of isolation. A strong case can be made that the families of handicapped children have needs for services beyond those designed for children and families in general, but that such services should be operated in accordance with the principle of normalization to ensure their maximum acceptability and usefulness. Toy libraries might carry out the function of providing support to the families of young handicapped children.

The rapid expansion of early intervention programs overseas and in Australia gives evidence of the hope held by parents and professionals that such efforts will prove beneficial. Many parents of handicapped children in Australia are seeking to promote the fullest development of their handicapped children, and they are displaying much interest in greater participation in promoting the development of their own child. Thus therapy and developmental programs for young handicapped children are in part focussed upon assisting parents to play a significant role rather than excluding them as was more common in the past. Toy libraries might play a role in providing therapy-related services to young handicapped children. The issue of co-ordination of therapy and educational intervention with toy library services will need careful examination.

8.4
THE SURVEY OF TOY LIBRARIES FOR THE HANDICAPPED

8.4.1
The Sample

A questionnaire survey of toy libraries serving handicapped children was conducted. Thirty-three completed questionnaires were received, this being a 73 percent response rate, from the 45 toy libraries identified as existing to provide special service to handicapped children. Some information was obtained regarding most of the toy libraries which did not return questionnaires. Figure 8.2 on the following page shows the geographic location of the toy libraries. It will be noted that though not every toy library for the handicapped could be precisely located (41 of the 45 are shown); little access to toy library services appears to exist outside major cities. Some city toy libraries consequently have developed mobile services ranging over a relatively large territory. Some relatively large population centres have no toy libraries for handicapped children. Ten cater for children with a single handicapping condition and 23 have a clientele with a wide range of handicaps. There were 18 community-based toy libraries in the sample, 13 resource units served specific facilities or agencies and two were based at Colleges of Advanced Education.

Toy libraries in Australia which returned questionnaires have been in operation for periods from less than a year to nearly nine years. The oldest toy library among the respondents is the Noah's Ark in Melbourne (8 years 9 months). This library has been of substantial assistance in the establishment of other toy libraries. Another well-established toy library is the ESSO Toy library (N.S.W.) for Autistic Children (7 years 6 months). Two other toy libraries complete the oldest group, all in operation over six years: Noah's Ark, Canberra, and the Monnington Toy Library in Victoria for visually and hearing impaired children.

The most recently established toy libraries in the sample have been in operation for less than two years. Again, there is no one type of toy library in this group. Five of the seven toy libraries in the group serve children with diverse handicaps; two serve children with specific handicaps, i.e. sensory (RVIB) and intellectual (Strathmont). Of those serving children with diverse handicaps, only one is a Noah's Ark Toy Library (Bendigo). Two of the other three are regional toy libraries (the South West Region Support Group Toy Library in Victoria and the North West Region Toy Library in Victoria and the North West Region Toy Library in Mt. Isa).

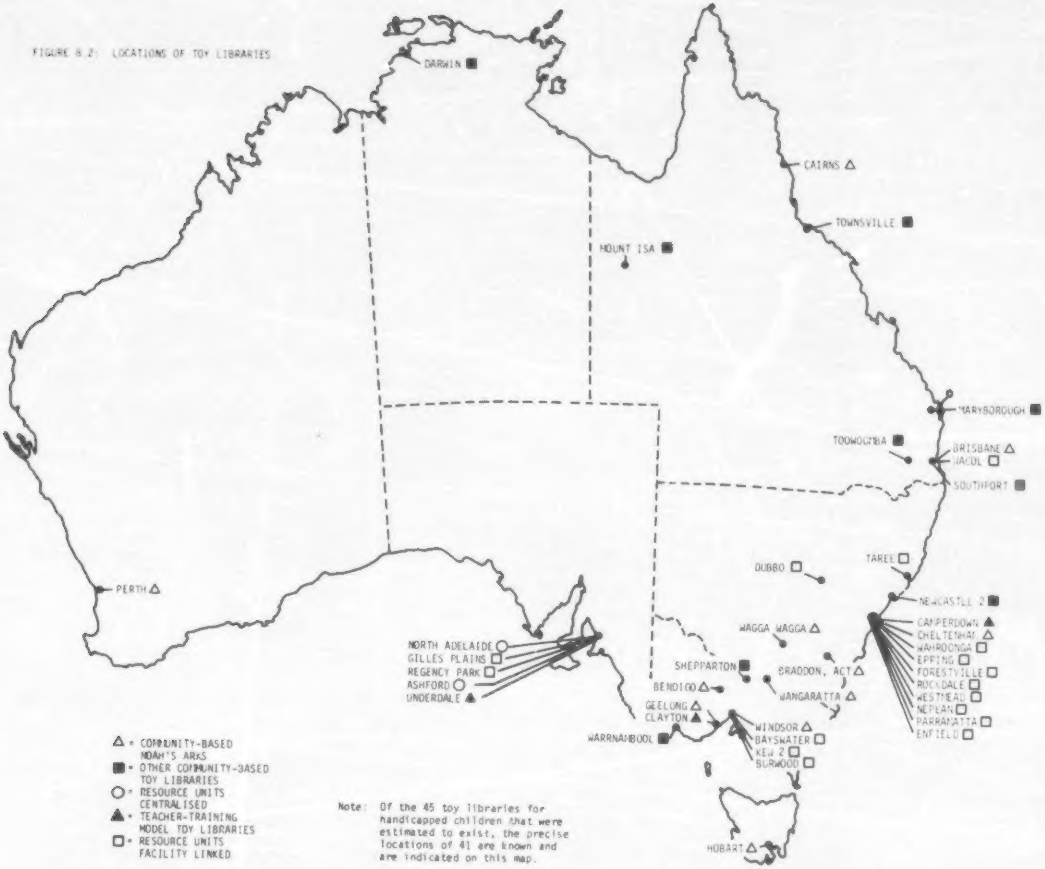
Thus diversity characterizes the most recently established as well as the earliest toy libraries in Australia. From the beginning to the present, toy libraries have included independent services serving all children with handicaps and services attached to previously established agencies or groups, frequently serving children with specific handicaps and using toys as programmatic tools.

8.4.2
Services Offered

All 33 toy libraries offered toy lending services. Among other major services were:

Consultation with parents	25.76%
Education on play and toy use	30.90%
Reference library for parents	26.79%
Resources for professionals	27.82%
Back-up service for related agencies	17.52%
Diagnosis	2.6%
School holiday activities	8.24%
Group activities for parents or children	15.45%
Assessment of clients	11.33%

FIGURE 8.2: LOCATIONS OF TOY LIBRARIES


DARWIN ■
CAIRNS △
TOWNSVILLE ■
MOUNT ISA ■
MARYBOROUGH ■
TOOWOOMBA ■
BRISBANE △
WACOL □
SOUTHPORT ■
PERTH △
TAREE □
DUBBO □
NEWCASTLE 2 ■
CAMPERDOWN ▲
CHELTENHAM △
WAHROONGA □
EPPING □
FORESTVILLE □
ROCKDALE □
WESTMEAD □
NEPEAN □
PARRAMATTA □
ENFIELD □
WAGGA WAGGA △
NORTH ADELAIDE ○
GILLES PLAINS □
REGENCY PARK □
ASHFORD ○
UNDERDALE ▲
SHEPPARTON ■
BRADDON, ACT △
BENDIGO △
WANGARATTA △
GEELONG △
CLAYTON ▲
WARRNAMBOOL ■
WINDSOR △
BAYSWATER □
KEW 2 □
BURWOOD □
HOBART △
△ = COMMUNITY-BASED NOAH'S ARKS
■ = OTHER COMMUNITY-BASED TOY LIBRARIES
○ = RESOURCE UNITS CENTRALISED
▲ = TEACHER-TRAINING MODEL TOY LIBRARIES
□ = RESOURCE UNITS FACILITY LINKED

Note: Of the 45 toy libraries for handicapped children that were estimated to exist, the precise locations of 41 are known and are indicated on this map.

Mobile van services were provided by nine toy libraries, with three more planning such activity. Ten mail services were noted, but it was not usually a method of choice.

Home visiting was provided by 13 toy libraries, but visits were typically infrequent, usually serving to overcome difficulties faced by parents in attending the toy library. However, visually handicapped children were more often visited at home to help promote development in that particular context. A wide range of other services was mentioned by at least one toy library, including:

1. visiting various service agencies to determine their needs so as to provide toys in response to requests for toys by therapists with those agencies;
2. using extended services to test client response and determine needs ("e.g. before branches are established, van visits are used ... to see if a need really exists.");
3. informal visiting by director and committee members in times of special need;
4. discussions of children's developmental stages;
5. a "social activities group for older handicapped persons ... once a fortnight";
6. in the case of toy libraries located in residential institutions, visiting in the villas or residences; and
7. acting as a training centre for special education students and others, through formal courses, in-service and workshops.

8.4.3
Operation of Toy Libraries

Most toy libraries were open fewer than 10 hours per week, but some opened for as many as 50 hours per week (Table 8.1). Community-based services tended to have the most restricted hours of operation. Factors such as dependence on voluntary staff or insufficient funds were cited as reasons for low hours of opening.

Table 8.1

Toy libraries categorized by number of hours of service per week

No. of hours	*No. of toy libraries*	%
1-5	7	21
6-10	7	21
11-15	4	12
16-20	2	6
21-25	2	6
26-30	2	6
31-35	3	9
36-40	3	9
40+	3	9
Total	33	100

Some 39 percent of toy libraries were not open outside normal working hours but most did offer early, late or weekend services at least occasionally (Table 8.2).

Table 8.2
Toy libraries offering services outside the normal working day

Service time	*No. of toy libraries*	%
No service outside working day	13	39*
Any weekday:		
after 5 p.m.	9	27
before 9 a.m.	7	21
Any week-end day:		
monthly	6	18
weekly/fortnightly	2	6
Any service - irregularly or by appointment	4	12

* Categories permit multiple responses

8.4.4
Clientele

Most toy libraries served children with diverse handicaps (Table 8.3), while two indicated that non-handicapped children figured substantially among their clients. Toy libraries serving children from within a specific diagnostic category tended to be associated with an agency or facility for handicapped children.

Table 8.3
Primary categories of disabilities catered for
by respondent libraries

Category	*No. of toy libraries*	%
Intellectual	3	9
Physical	3	9
Sensory	3	9
Autistic	1	3
Diverse handicap	21	64
Handicapped & non-handicapped	2	6
Total	33	100

Only two toy libraries served predominantly adolescent or adult clients, and these services were associated with residential facilities. While many toy libraries served a wide age range, the predominant age group was pre-school and primary school children (Table 8.4).

Table 8.4
Approximate age ranges of the majority of clients
at the libraries

Age range	*No. of toy libraries*	*%*
0-5	9	28
5-12	5	16
0-12	8	25
11-16	1	3
5-16	1	3
16+	1	3
No particular age group	7	22
No answer	1	
Total	33	100

The client population for the toy libraries varied widely from fewer than 100 clients in places like Mt. Isa, Cairns, Shepparton or Dudaloo, to several thousand, Noah's Ark, Melbourne and the Special Education Resource Unit (South Australian Education Department) being largest.

Table 8.5
Extent of toy library use in terms of client numbers
by organizational characteristics

Type of client	*Community-based (n=18)*	*%*	*Other (n=14)**	*%*	*Total (n=32)*	*%*
Handicapped clients	5495	37	1653	64	7148	41
Non-handicapped clients and/or siblings	529	4	495	19	1024	6
Estimated borrowers in client groups	9041	60	418	16	9459	54
Total clients **	15065	100	2566	100	17631	100
Mean	837		183		766	
Median	290		143		290	
Minimum	29		45		29	
Maximum	6666		508		6666	

* The Special Education Resource Unit has been excluded from this table because of the uncertainty associated with derived figures.

** These figures are based in some cases on estimates.

The Special Education Resource Unit has not been considered in the preceding analysis because of difficulty in estimating the total number of its clientele. However, over 17,000 clients were estimated to use the toy libraries in the sample (Table 8.5), about half of whom were direct borrowers and half were served through their membership in client groups such as pre-schools or schools.

Almost all clients were handicapped (95%) with siblings of handicapped children constituting most of the 5 per cent of non-handicapped borrowers. The community-based toy libraries appeared to serve a larger clientele per facility (an average of approximately 840), than did other toy libraries which averaged about 180 clients each. The pattern of services to siblings is summarized in Table 8.6 It will be noted that about 64 per cent of the toy libraries offered some service to siblings, but only 12 per cent offered them full service.

Table 8.6
Types of services available to siblings
from respondent toy libraries

Type of service	*Community-based*	%	*Other*	%	*Total*	%
Direct but diminished service to siblings	7	39	7	47	14	42
Direct and equal service to siblings	3	17	1	7	4	12
Indirect services to siblings	2	11	1	7	3	9
No services	6	33	6	40	12	36
Total	18	100	15	100	33	100

8.4.5
Toy Library Facilities

More than half of the toy libraries shared facilities with other users, but only seven of these 23 owned the building, as did six toy libraries in the "sole use" category. Eleven toy libraries paid no rent and nine were renting premises. Few toy libraries had purpose-built facilities (5 of 33) and only one of these was a community toy library.

About half the toy libraries regarded their premises as appropriate, with greater satisfaction among the resource unit toy libraries. Of nine elements which might have been expected in the premises, none was present in more than half of the toy libraries (Table 8.7).

Table 8.7

Facilities of respondent toy libraries

Feature	*No. of toy libraries*	*%*
Toilet	17	52
Indoor play area	15	45
Office	11	33
Store room or storage area	10	30
Outside play area or facility	20	60
Display area	8	24
Waiting/reception area	8	24
Parents' meeting room	4	12
Kitchen	4	12

A statement of minimal facility requirements for a toy library cannot be made because the range and scope of toy library services are so varied. What is necessary to one toy library may be superfluous for another. An attempt was made, however, to see if common elements could be found for the 16 toy libraries which judged their building to be generally appropriate. However, the only two common facilities mentioned by the majority of such toy libraries were playrooms and toilets. These findings may reflect the fact that playrooms can serve multiple purposes. For example, depending on size and design, they may be used for display, storage, and for parent meetings (perhaps in a conversation corner).

The stock of toys ranged from around 200 to over 8,000, with a ratio of number of toys per client ranging from 0.5 to 13.3. The distribution of number of toys owned in relation to number of clients is shown in Table 8.8.

Table 8.8

Number of toys owned in relation to number of clients (N-30)

No. of toys (x 100)	*0-5*	*>5-10*	*>10-15*	*>15-20*	*>20*	*Total*
No.of clients (x 100)						
0-1	6	2				8
>1-2	4		1			5
>2-3	1	2	2			5
>3-4	1		1	1	1	4
>4-5	1		1			2
>5				1	5	6
Total	13	4	5	2	4	30

Another measure of the available toy resources is the number of toys which would be borrowed per visit (most commonly two). There does not appear to be a strong relationship between this administrative measure and the number of toys available per client, and some toy libraries permit borrowing at a rate which, if observed, would exceed resources (Table 8.9).

Table 8.9
Number of toys allowed per visit
by number of toys available per client (N=29)

No. of toys available	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*>9*	*Total*
No. of toys allowed											
1			2		1						3
2	1		1	1	3	1		1	1	1	10
3	1		3	1	1						6
4	1	1		1							3
5	1										1
6							1			1	2
>6	2		1							1	4
Total	6	1	7	3	5	1	1	1	1	3	29

8.4.6
Communication

Government department agencies appeared to refer clients to toy libraries, especially those operated by health and education departments and, less frequently, by welfare departments. Voluntary organizations serving the handicapped also made considerable use of toy libraries. Among professional categories, referrals were most common among therapists and other medically trained persons, with educators and social workers referring clients somewhat less frequently. There was also some significant informal referral from clients and relatives, and self-referral as a result of public awareness campaigns by toy libraries.

Table 8.10 indicates the extent of communication among toy libraries, the community and clients.

Table 8.10
Methods of communication with the community,
prospective clients and existing clients

Methods	*Prospective clients (n=33)*	*Existing clients*	*Community generally*
Personal discussions	6	11	10
Talks/meetings	5	3	17
Letters/newsletters	13	24	8
Media (radio, television, press)	5	5	16
Posters/pamphlets/brochures films/displays	18	14	5

It will be noted that a wide range of procedures is used by toy libraries but, with the exception of newsletters to existing clients, no one method is used by most toy libraries.

8.4.7

Staff

Details of staffing for the toy libraries are set out in Table 8.11.

Table 8.11

Details of staff numbers in toy libraries

Occupation	*Community-based (n=18)*	%	*Other (n=15)*	%	*Total (n=33)*	%
Library advisors*	140	68	62	78	206	72
Other workers*	67	32	17	22	80	28
Total workers*	207	100	79	100	286	100

* Includes both part and full-time workers.

The distinction between'library advisors' and 'other workers' was found to be somewhat arbitrary by many who completed questionnaires. The latter was designed to include clerical staff, maintenance workers and van drivers. The mean number of workers per toy library was 8.7, being 11.5 in community-based toy libraries and 5.3 in others, where often staff belonging to the associated agency could provide some assistance. Also, since volunteers were predominant in community-based toy libraries (74%), in contrast to other types (4%), the larger staffing ratio of community toy libraries reflects the presence of many volunteers who work relatively shorter hours than do paid staff (Table 8.12).

Table 8.12

Voluntary staff numbers in toy libraries

Vocation	*Community-based (n=18)*	%	*Other (n=15)*	%	*Total (n=33)*	%
Volunteers*	153	74	3	4	156	55
Paid workers*	54	26	76	96	130	45
Total workers*	207	1C0	79	100	286	100

* Includes both part and full-time workers.

Of the total 286 staff, 162 were listed as having had previous experience with handicapped children. This total includes volunteers such as the ten at the Noah's Ark Toy Library in Wagga Wagga, who were mostly themselves mothers of handicapped children. The questionnaire did not allow the toy libraries to differentiate between those staff who had obtained their experience by working at the toy library for quite lengthy periods and those staff members who had had previous experience with handicapped children in other contexts. The length of time staff had been working for the toy library can be another indication of experience with handicapped children that the staff have had. Thirty-three staff were listed as having worked for the toy library for over two years, with staff members at Torrens Noah's Ark Toy Library in Melbourne having been with the toy library for up to five years. Nearly half (131) of all staff had been with their toy library for at least 12 months. Most of the staff had not worked in any other toy libraries, and this would be expected, partly because of the geographical positioning of toy libraries.

8.4.8
Organization and planning

Questions to toy libraries focussed on three aspects of organization and planning:

(1) Administrative characteristics and procedures of current operation;

(2) Existing procedures for planning of future services; and

(3) Expectations of future services in the next five years.

All of the Noah's Ark toy libraries in the sample were registered charities, as were some other community-based toy libraries. Administrative and financial management procedures of independent toy libraries not associated with a larger agency or department appear to follow a similar pattern. Most describe a highly interactive relationship between toy library staff and governing committee.

A few community-based toy libraries are somewhat dependent on a group or community service agency with which they are closely associated. For example, the North West Region Toy Library at the Mt. Isa public library notes that "most running costs are absorbed in the library budget. Even expenditure on toys comes under the audio-visual budget item"; and the Kath Dickson Toy Library in Toowoomba is staffed by Family Day Care staff members who liaise with the sponsoring body, the Toowoomba Family Care and Support Association.

The resource unit toy libraries vary somewhat in administrative set-up depending on the type of organization with which they are associated. The administration may be bound up with a larger service, as in the case of the Royal Victorian Institute for the Blind toy library or the Royal Blind Society of N.S.W. toy library. On the other hand, such a toy library may have a degree of independence. For example, the Wooden Horse Toy Library has a bank account that is independent of St. George's School for Crippled Children or the New South Wales Society for Crippled Children.

Policy development at the individual toy library level appears to be ad hoc and dependent upon the particular personnel involved. However, some toy libraries did indicate that representatives of other agencies serving similar client groups were involved. However, a more systematic statewide and national policy and planning component is lacking. The toy libraries themselves have made a beginning through their Association, but as with the efforts of individual toy libraries, there is insufficient involvement of and co-ordination with government and voluntary agencies for family support or welfare of handicapped children. Planning appears to be primarily in the hands of staff and governing committees, where they exist.

About two-thirds of the toy libraries indicated that they wanted to expand the range of services offered if they could receive sufficient funding for expansion. The major areas mentioned were mobile lending services, organized supplementary activities, parent education, support and consultation, and home visiting.

Some comments made concerning expectations of services five years in the future were very similar to those in response to the question on hoped-for directions of expansion of services if additional funds were available, though answers to questions on expectations were richer and more detailed. Answers concerning expectations tended to emphasize qualitative aspects of service rather than scope or range of services. For example, whereas the Kath Dickson Toy Library had earlier listed six services that would be advantageously added if funding were available, the expectation was that the major improvement would be "closer liaison with agencies" with "consequent benefits to the teachers, therapists and families with whom they are involved".

About half of the toy libraries had determined the nature and extent of needs in the community which might be met by their toy library service, mostly prior to the establishment of the service. Procedures used included examination of records or organizations and questionnaires to parents and/or groups and agencies. Few toy libraries were aware of any wide-ranging surveys of the needs of handicapped children in their region which might have implications for toy libraries. It was clear that the work carried out at Nottingham University by Newson, Newson, Head and Mogford was the most significant research to influence toy library services, while Noah's Ark Melbourne and Torrens Toy Library have helped disseminate research evidence to other toy libraries in Australia.

One third of the toy libraries reported having made some evaluation of the effectiveness with which they were achieving their aims and/or meeting their commitments, usually by monitoring usage both in quantity and quality. Another approach was to survey clients, by telephone, personal interview or questionnaire. Only one toy library mentioned evaluation of children's development. Two examples of external evaluation were given: one was a student project, the other was a necessary consequence of Schools Commission funding.

Most toy libraries felt that toy libraries were a well established feature of special education services. A few toy libraries reported on growth in client numbers as indirect evidence of acceptance, but most were able to cite examples of their belonging to a network of community resources.

Although several themes emerge in the projections for the future made by toy libraries, no single idea was proposed by more than one quarter. There was strong support for increased co-ordination of toy library services at state or regional level. This seemed particularly so for toy libraries not attached to other facilities for the handicapped. This co-ordination was seen as growing both in administrative and service aspects such as information, and public education. A second major theme was for government funding to be made more secure to permit stable operation and planning. Most toy libraries saw a continuing role for volunteers and for charitable fund raising. Only one toy library mentioned the establishment of standards for toy libraries, but several noted the need for training of toy library staff.

8.4.9
Funding

Initial funding levels (in thousands of dollars) are summarized in Table 8.13. It will be noted that initial funding represents only cash requirements. The wide range, from $150 to $31,000, indicates that considerable support 'in kind' was available for some toy libraries.

TABLE 8.13 Total funding for initial establishment of respondent toy libraries

Funding ($'000)	*No. of toy libraries*	%
0-1	5	19
>1-2	5	19
>2-3	4	15
>3-4	1	4
>4-5	1	4
>5-6	3	11
>6-7	1	4
>7-8	1	4
>8-9	1	4
>9-10	1	4
>10	4	15
No answer*	6	
Total	33	100
Mean	$ 6176	
Median	$ 3000	
Minimum	$ 150	
Maximum	$31000	

* All these libraries were resource units which had more difficulty providing information.

Almost all of the budget of the great majority of toy libraries was spent on providing toys, equipment or books. Sources of funds were identified according to government, community services, committee or other categories. Some $23,400 was provided from the federal government, notably the Office of Child Care of the Department of Social Security, but only five toy libraries indicated having received federal assistance for initial establishment, and one of those did not indicate the amount received. Nine toy libraries received state government assistance, with amounts ranging from $500 to $12,000, with three amounts not specified. Five examples of local government assistance were noted, the amounts being smaller, from $250 to $2,000 or the free use of council rooms for housing the toy library. Direct toy library committee fund raising and donations from service clubs were also important.

Eleven toy libraries, nine of which are community-based, received federal funding for continuation of services since the time of their establishment. The largest contributor, as for establishment grants, was the Office of Child Care, with the former Australian Assistance Plan (administered by the Department of Social Security from 1974 to 1977) providing substantial amounts as well.

A total of $229,000 in contributions by federal agencies was reported from a total of eleven toy libraries between 1974 and 1979, with amounts ranging from $300 to $21,900 in a given year. State government departments also became involved in funding. Five community-based toy libraries, four resource units and one teachers' college toy library indicated that no direct state or federal funds were available; and they appear to survive on local government grants, college support, donations, and fund-raising.

The resource unit toy libraries tended not to charge fees; of 13 resource units, only 4 (30%) charged any fees and, with the exception of one, these were associated with schools for the handicapped. Of the 18 community-based toy libraries, 12 (67%) charged fees of some kind. Fees usually involved (1) a fee for joining the toy library, ranging among toy libraries from 50 cents to $5.00 for a client and/or his family and from $2.00 to $25.00 for groups; (2) an annual membership fee from 50 cents per year to $10.00 per year for individuals or families and from $10.00 to $25.00 per year for groups. In addition, borrowing fees ranging from 5 cents to 50 cents per toy were frequently charged, and replacement costs were charged for lost or damaged toys.

8.5
PARENT VIEWS ON TOY LIBRARY SERVICES

Three studies which tapped parent views were identified. These were carried out at the Melbourne Noah's Ark, the Torrens Toy Library and the Colony 47 Toy Town Library in Hobart. These served to inform the toy libraries about client satisfaction. Benefits noted by parents were primarily financial saving and availability of a wider range of appropriate toys. Social benefits for children and parents were also acknowledged.

The research team also conducted a study (among parents) of four toy libraries in Queensland. The utility of the toy library services was rated as very high by most parents. The primary services valued were toy related: toy lending, advice on choosing toys and gaining understanding how toys contribute to development. It was also clear that the toy library offered a unique service, especially in country areas.

8.6
TOY LIBRARIES FOR THE HANDICAPPED - AN OVERVIEW

The provision of special toy libraries for handicapped children arose in order to ensure that the developmental play needs of such children received appropriate attention. Such provision may be made within regular services (e.g. regular toy libraries or even as part of book libraries), but unless regular services make provision for adequate attention to their special needs, handicapped children do not receive appropriate services and may become further disadvantaged. Some handicapped children appear to be adequately serviced by regular toy libraries. In cases where non-handicapped siblings were encouraged to participate in a toy library for the handicapped, benefit was noted for both the handicapped child and the family. Thus, if funding levels permitted, the distinction between toy libraries in general and those specifically for the handicapped might prove unnecessary. Co-operation between toy libraries and community playgroups was evident in some of the community-based toy libraries, and the relationship was used to assist parents to extend their range of understanding of the use of toys. The resource unit type of toy library displayed a different relationship to related services, primarily providing a collection of toys that could be utilized in other programs for children. Demands on toy libraries change as other services, such as schools, become better provided with toys, play things, and other educational tools. On the other hand, the development of toy library mobile van service focuses directly on taking at least a partial range of toys into areas otherwise without access to such a service. Whether a child chooses toys or has toys selected for him by professionals for specific developmental or therapeutic purposes is associated with factors such as the philosophical orientation of the staff towards play, the primary purpose of the toy library, the number of toys available, and the age and abilities of individual children.

Although the name 'toy library' suggests the toy component of the service, there are signs of an expansion in the function of toy libraries for the handicapped. The extent to which family help is considered to be an aspect of toy library services varies a great deal, from no contact with families at all, as in the case of some resource units, to very extensive contact.

Professional staff of toy libraries and the Australian Association of Toy Libraries for the Handicapped recognize the importance of the interaction which takes place between staff and the family of the handicapped child. It seems axiomatic that staff should have skills that enable them to relate appropriately to family needs. Indeed, community toy libraries also engage in various kinds of family support and counselling which focus on wider issues than the needs of the handicapped child who is the ostensible client.

The name 'toy library' is perceived to be of value in its connotation of a non-stigmatized service centre for children. Many parents bringing children to toy libraries have also expressed their appreciation of the value of the accepting atmosphere afforded by a toy library. This type of comment was especially evident in cases where toy libraries provide some programming or counselling, or situations where they facilitate the formation of parent support groups. The difference in atmosphere may be compared with the clinical formality of traditional therapy or educational services in which parents and siblings are often ignored.

Some toy libraries provide recreation extending beyond the lending of toys. When services are extended to adult handicapped people, the appropriateness of the term 'toy library' needs serious questioning. At a time when there is growing awareness of the dignity and rights of individuals, and age and 'norm' appropriateness of activities provided for handicapped people, the name given to a service becomes a sensitive issue. In an area such as recreation, where an integral aspect of lifestyle is concerned, the handicapped adult has particular need to identify with adult activities rather than those which are seen to be the domain of children.

Toy libraries are most likely to be the direct responsibility of persons who come from any one of a number of different professional backgrounds, such as early childhood education, special education or one of the therapies. There seems to be some debate between those associated with toy libraries, as to whether professional staff or non-professional staff should be employed. Those who advocate professional staff may have special concern for the counselling role in relation to selection of appropriate toys and advice to parents and may also recognize the importance of establishing standards of professional competence and operational patterns for toy libraries. There is also widespread recognition of the role of the unpaid volunteer in the conduct of toy library services.

Advocacy for non-professional staff relates to both paid and volunteer situations, to parent-run services, and to non-professionally operated services with or without consultant professional services. In some instances, volunteers and parents are people with relevant professional backgrounds themselves.

The response to an immediate need, such as the formation of a toy library service, seems to create a means by which, in many instances, other gaps in community services for the handicapped, which have not previously been evident or expressed, are addressed.

Once a need for a toy library service (and associated services) is identified, it would seem that one of two courses of action could be followed. One would be to establish an independent toy library service; the other would be to investigate the range of relevant existing services (e.g. community centre, local library, agency or centre for disabled people, toy library service for non-disabled children) to determine whether a toy library service to serve handicapped children and their families can be provided as an extension.

Changing needs for toy library services are related to changes in population and likely changes in the effectiveness of other services; especially early intervention, which may also involve provision of toys. Outcomes of such evolving needs are difficult to predict.

Relationships between toy libraries and other services can be viewed from different perspectives according to the primary focus of the interaction that occurs. The type of interaction may be in terms of information, expertise, staffing, funding or services. Other organizations providing services with which a toy library may interact include services for disabled people, services for children, services associated with leisure interests and governmental departments or funding sources. While co-ordination is an important issue to address, it is necessary first to identify relevant services, the types of relationships which exist between such services, and the ongoing needs relevant to the overall service delivery pattern.

The majority of toy libraries throughout Australia belong to the Australian Association of Toy Libraries for the Handicapped, thus having potential for input into its activities and for being influenced by this association. From its beginning as an association promoting toy library services, AATLH has become an active advocate for the improvement of the quality of these services. It expresses strong views concerning the need for professional staff, staff training, the importance of volunteers and the value of the name 'toy library'.

Informal ties rather than formal ones exist between relevant professional organizations and the toy libraries. Such ties occur through staff membership in their professional associations rather than at an organizational level.

The essential relationship between government at all levels and toy libraries has been concerned with funding. The pattern differs according to whether the service is part of a government or voluntary agency or is autonomous.

The primary relationship with government has been based on toy library needs for funding, either to establish a service or to ensure that a service continues after other means have been used for establishment. Associated with such a relationship is the need for government funding sources to be aware of the nature of a toy library and its particular funding needs. Evaluation and accountability ought to be closely related to the government funding role.

Some toy libraries also have relationships with government in the area of delivery of services. In these instances any interaction that occurs is likely to involve referral of a client to the toy library or the provision of consultant or advisory services. In other instances, a government department providing a service to handicapped children may become a group client of the toy library.

Toy library services are a specialized service within the broader context of services for children, especially those with handicaps. They can also be classified as a specialized service within the broader context of library services which, in turn, can be encompassed within the very broad area of community recreation services. In the case of toy library services meeting the needs of disabled children, the specialization links children's and recreation services to those for the handicapped.

The type and range of children's services and recreation services available to any one community are likely to determine the initial location of a toy library and to influence subsequent interaction between services. In some cases, toy libraries have begun because communities lacked any services for handicapped children. In others, the toy library has been the last of many services to be created, and augments the richness of community resources. Where there is no interaction or very few relevant services, establishment of a toy library is likely to result in a wide range of additional demands on its resource and service potential.

Whether such extension results in filling service gaps or in duplication of services depends on whether there is an inadequacy in relevant service provision or an inadequate communication among available services and between services and the community.

Relationships to relevant services are related to whether the toy library is a resource unit within an agency or whether it is an autonomous community service. Relationships between autonomous toy libraries and other relevant services seem more likely to occur than relationships between within-agency toy libraries and other services. This is not at all surprising given the difference in purpose. Relationships between toy library services and other services tend to be informal rather than formal.

It would seem to be important in planning new toy library services that likely relevant related services be identified and that the potential relationship of the toy library to those services be assessed. In this way informal interactions can be facilitated, and where formalized relationships are perceived to be necessary they can be established also. The extent to which co-ordination of services is deemed to be necessary can then be evaluated. A national advisory body may play an important role in identifying need and giving direction to type and quality of services. Depending on individual community structures, voluntary co-ordinating committees or more formally appointed groups of this type would need to be associated with the broader spectrum of services rather than with expressing any isolated concern for toy libraries, and should have regard for the potential relationships between regular toy library services and toy library services specifically for disabled children.

The availability of funding is crucial to the establishment and operation of a toy library service. The type of funding needed, the importance of continuity of funds for providing ongoing services, and the funding implications of present services for future demands require careful consideration, and need to be examined in the context of early intervention services as a whole, and in the light of policies which affect libraries, recreation services and education.

Beyond the initial establishment of a service for lending toys, other services and functions are likely to emerge as part of the toy library role, and these will affect funding levels required. In some instances, extension of role is evident from the beginning, with planned provision for advisory services in relation to toys and parent counselling included. In other instances, the extent of latent demand which becomes evident when the toy library service is established is far beyond that which was envisaged. Such demands relate to extension of developmental or therapy services for both children and adults. There seems to be no one pattern or trend in this regard. The underlying factor seems to relate to the impact of the initial response to a local demand for a toy library, and the extent to which additional types of services are sought. The manner in which these issues are perceived by those operating the toy library will determine which funding implications emerge.

Special services for handicapped people have been recognized as important in Australian society, whether these services are provided separately or as an integrated part of regular community services. Developments in services for handicapped children have revealed the importance of the provision of appropriate services as soon as possible after disabilities are identified. On such a premise, programs for infants and young children have evolved, using specific educational and therapeutic techniques, although the research base is still being augmented. It is clear that there is considerable weight to arguments for early intervention even without a complete empirical data-base to support it.

Techniques used in both education and therapy have incorporated the use of a wide range of toys and playthings. Because of the diversity of toys needed for the clientele, expenses involved and the limited life of any particular toy, the desirability of a toy library service for children in general is becoming increasingly recognized. The very specific needs of handicapped children in this regard have highlighted the potential value of toy libraries for all children. It would seem, therefore, that the issues which emerge in a consideration of toy library services need to be seen in the light of these broader developments and of the values associated with service provision for young handicapped children.

Several basic issues have emerged from the study of toy libraries for handicapped children.

(1) Play is an integral aspect of the life style of the child and also has value as a medium for educational and therapeutic purposes.

(2) Toys and playthings are an important component of the play environment and a basic requirement for educational and therapeutic programs for young handicapped children.

(3) Educational and therapy programs need access to supplies of toys in order to meet the range of needs of the developing child. Individual children can benefit greatly by having access to a toy lending service.

(4) The handicapped child needs, even more than do non-handicapped children, access to specified types of toys for educational and therapeutic purposes and a range of experiences in order to learn to play and to experience the benefits of play activity.

(5) Based on these factors, toy library services, and special provisions for handicapped children within such services, are seen to be important.

(6) Services provided by a toy library are likely to expose other related community needs for which there may be no service or inadequate service. These may include family support, educational or therapy services for the disabled child, and recreation services for older children and adults.

(7) Toy library services ought to present a public image which causes them to be valued by the community, and their use by handicapped children ought to be consistent with the normalization principle.

(8) While toy libraries' primary functions relate to toy lending, these can be carried out most effectively when a transactional model of operation is followed in which client, family and larger community are considered rather than only the needs of the handicapped child who borrows toys.

8.7
FUTURE DIRECTION OF TOY LIBRARY SERVICES

Because of the specific attention given to toy libraries for handicapped children in the overall survey of early intervention, a large number of recommendations were made. Almost all are related in a complex and interactive manner to each other. This is particularly true where different types of toy library are considered. The recommendations are not repeated here, but a brief discussion of the future direction of toy library services reflecting the recommendations follows:

Community toy libraries are a significant component of toy lending services in Australia. While toy resource units associated with institutions serving children with disabilities and toy libraries for older children also play important roles, it is our view that toy lending services to young handicapped children up to school age should be carried out predominantly through community toy libraries open to all children with disabilities, regardless of alignment with particular agencies or groups.

As a relatively new form of service to young handicapped children and their families, toy libraries need careful examination as to the nature and extent of their relationships with existing and emerging services, particularly early intervention programs.

Because of the relatively short period during which toy library services have been in operation, there are not as yet established sources of funding. The past few years have been characterized by applications of toy libraries for funds wherever it was thought likely that support might be forthcoming. Toy libraries on establishment have received assistance from a variety of sources, but the ongoing maintenance of services appears to require some long-term commitment from public funding. Also important is the recognition of the principle that parents of handicapped children should not have greater expenses in meeting their children's needs than those experienced by parents in general.

Most importantly, certain underlying principles should be observed which are fundamental to the development of effective services. These include the normalization principle expounded by Wolfensberger (1972), the acceptance of accountability with its consequent demand for evaluation, and the centrality of play behaviour in the promotion of child development. Local and regional co-ordination will be needed to ensure appropriate and efficient services, while effectiveness will be enhanced by the recognition that toy library services need to be integrated within the constellation of services for the handicapped.

CHAPTER 9

CRITICAL ISSUES IN EARLY INTERVENTION

B.H.Watts, A.Hayes & W.C.Apelt

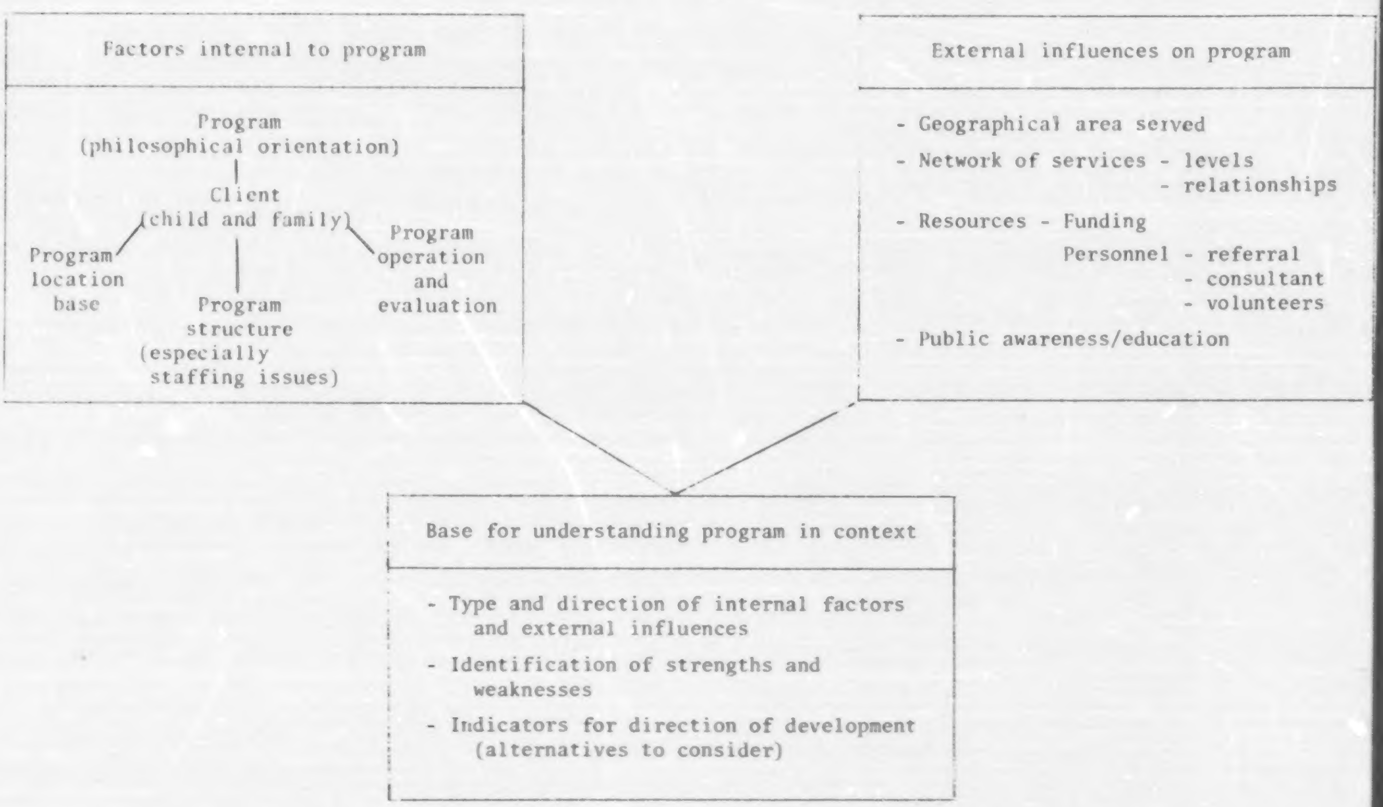
Throughout this study, we have sought to enrich our theoretical understandings through our site visits and the data provided on a wide range of programs, and the perspectives shared with us by parents, program staff, departmental officers and administrators of voluntary associations. On these bases, we have sought to identify and to evaluate the pattern and nature of early intervention services and programs available for young handicapped children and their families in Australia.

We see the major outcome of our study as being the identification of the key issues which need to be addressed if appropriate and effective intervention programs are to be offered to young handicapped children and their families throughout the nation. As we note, research evidence provides no incontrovertible guide to a single approach or solution to issues such as, for example, groupings of children (similar handicap *vs* diversity of handicap), curriculum (direct instruction *vs* eclectic approaches), degree of involvement of parents (little program role *vs* central role). While aspects of early intervention have been researched, thoroughgoing longitudinal studies which examine the child and his family in their complex ecology have yet to be undertaken. We return to this issue at the end of this chapter. Yet this is not to suggest that research has not identified certain principles to guide policy makers. Even in relation to the above issues, research and theory can delineate what seem to be the minimum essential characteristics of effective programs and can certainly indicate major weaknesses which need to be avoided. Beyond this, there are some issues where policy makers, program developers and parents will be guided by their own philosophies about the rights and needs of handicapped children and their families; the philosophic position taken by each predetermines decisions about the range of program attributes.

Throughout the ensuing discussion, the complexity and the interrelatedness of the key issues are highlighted. Both the planning of services and, subsequently, their evaluation need to take account of these characteristics. The interrelationships which we see to be of particular significance are illustrated in Figure 9.1. Thus, to understand a particular program within its context, we need to know the attributes of the program and of the clientele served and the interactions among these factors. In addition, our understanding is dependent on our knowledge of external forces which impinge upon the program-in-operation; these forces determine, for example, the resources available to the program, including the level of staffing. Again, where the program operates in a country area, unsupported by any network of

Figure 9.1

The Interrelatedness of Issues in Early Intervention


Factors internal to program
Program
(philosophical orientation)
Client
(child and family)
Program location base
Program structure (especially staffing issues)
Program operation and evaluation
External influences on program
- Geographical area served
- Network of services - levels
- relationships
- Resources - Funding
Personnel - referral
- consultant
- volunteers
- Public awareness/education
Base for understanding program in context
- Type and direction of internal factors and external influences
- Identification of strengths and weaknesses
- Indicators for direction of development (alternatives to consider)

services, the implications for parents and their role in the program vary from those which might be the case in a city where the program is offered by one department with co-ordination with other relevant agencies.

We turn now to address the issues of:

- the concept of early intervention: its nature, its clientele and its program staff;
- program issues;
- the service delivery system: responsibility for provision, the co-ordination of services, regionalization and staff training; and
- ongoing research and evaluation

9.1
CONCEPT OF EARLY INTERVENTION

9.1.1
Underlying Philosophical Orientations

One stimulus to the development of particular services and programs comes from the philosophical orientations to early intervention held by planners. These may be viewed across a number of dimensions which, while not independent of one another, derive quite clearly from different assumptions about the nature of development and the associated form of programming to be adopted:

- A remedial *vs* developmental emphasis.

  The former typically stresses an intense structured program usually directed to a restricted set of developmental areas, whereas the latter seeks to facilitate the child's general developmental processes. Both aim to optimize development but see the way this will be achieved in quite distinctly different fashions. The remedial emphasis sees the program as the agent of developmental change; the developmental emphasis, in contrast, views the facilitation of experience as the way of enabling the child to develop fully his or her potential.

- Early intervention *vs* life span emphasis.

  The former strives to develop a comprehensive set of services for the young handicapped child, assuming the primacy of the early years of life. The latter, noting the emergence with increasing age of new needs requiring different approaches, sees early intervention as the beginning of a process of life span developmental intervention; it assumes the need to seek clear articulations between early intervention programs and the services to be made available as the young child grows and, in particular, the need for a common philosophy to inform these sequential programs and services.

- Segregated *vs* integrated service delivery emphasis.

  The emphasis on segregation has historical antecedents reflecting, as it does, the evolution of services for the handicapped. It also reflects the assumption that the needs of handicapped people can best be met in an environment specifically tailored to meet their particular characteristics and to cater for their specific exceptionality. In contrast, the integration emphasis reflects a belief in the importance of normalization and the provision of services in the least restrictive setting.

  This is not to suggest that segregated settings are necessarily non-normalizing; however, the press for integration seeks not only to establish the least restrictive setting for the handicapped child but also to provide social experience of handicap for those without disability. A central assumption in this emphasis is that, via the contact between the handicapped and the non-handicapped, the inaccuracy of stereotypes of the disabled will be recognized and the handicapped valued in their own right. Integrating the handicapped into the mainstream of society may be a long-term goal rather than a short-term objective for early intervention programs. Thus, severe handicapping conditions in young children may require more restrictive environments than the regular preschool; the particular needs of some handicapped children necessitate access to the trained expertise of special education personnel and specialized adjunct services. Nevertheless, the intent of the provisions and the manner of their delivery can be predicated on a valuing of normalization.

- Child-centred *vs* family-based emphasis.

  The former emphasis assumes that intervention efforts can be concentrated on the child alone; the latter, in contrast, believes that development is a process not restricted to the program and child but rather one which must involve the salient people in the child's environment. In so emphasizing the family, this approach shows the influence of the recent recognition of the importance of adopting ecological models of human development. In addition, it also reflects the emerging awareness of the need to provide supports to the family undergoing the, at times, oppressive stress of coping with the birth and uncertain developmental future of a young handicapped child.

It has been clear throughout the discussion of early intervention programs in preceding chapters that a diversity of combinations of positions exists in Australia with regard to these four major philosophical orientations. Further, elements within programs may reflect quite distinct sets of assumptions. This situation serves to underscore the complexity of possible approaches to what can mistakenly be represented as a unitary concept of early intervention.

It would be neither possible nor desirable to seek a unified national approach to early intervention. Rather the existence of a diversity of approaches is, at this stage, a healthy situation. From such diversity there should evolve a number of viable alternatives, each tailored to the exigencies of clientele, the uniqueness of their needs, the regional differences in resources and the services available for the mobilization of these resources. There is thus a need for national and state policies that enable service deliverers in each region to capitalize on the diversity which exists, while avoiding unnecessary duplication and directly moving to eliminate the inequities in the availability of services across regions.

9.1.2
Program Clientele

The review of programs has clearly revealed the diversity of clientele either receiving, or potentially in need of, early intervention services. The focus of programs varies. The particular clientele served in part reflects the traditions of service delivery; for example, educational agencies may be more inclined to concentrate on the pre-school aged child than upon the infant and toddler. Programs within health and welfare agencies may show a greater willingness to regard the whole family as the client. At the same time, it must be added that many educational agencies are currently beginning to address the problem of serving the needs of the family, and in so doing are changing the traditional focus of educational intervention.

These attempts are at times frustrated by the inability of such educational agencies to employ personnel traditionally associated with health and welfare services. Ironically these agencies may also be expected to deliver early intervention in a form that parents can identify with the accepted concept of schooling for older non-handicapped children. As long as these situations persist, service delivery to the family as client is likely to be piecemeal. While economic and administrative realities may preclude radical reorientation of the focus of educational agencies involved in early intervention, it should, however, be possible to achieve better co-ordination of existing services in education, health and welfare agencies to provide complementary sets of program elements. If this occurred it would represent a relatively efficient way of providing the services required to meet the needs of both child and family. The services of welfare departments may need to be an integral part of the intervention program for some families. Handicapped children are born not only into well-educated, well functioning families, but also to single mothers, to poor families, to vulnerable parents, and the fact of handicap may be only one of the problems currently faced by the family. Whilst it is recognized that in some cases the birth of the child, irrespective of handicap, can be a source of great richness in the life of some families, in others such an event may have disastrous ramifications.

Again it must be recognized that the needs of the family as client extend beyond the period of time during which the child receives early intervention. Ultimately the focus of school programs meeting the needs of the child following early intervention must change in order to meet the concurrent needs of the family; to achieve this,better co-ordination with health and welfare agencies will be essential. The issue of co-ordination is further explored later in this chapter.

Furthermore, the needs of the family as client change as the child develops and vary quite considerably with the type and degree of the child's handicap. Many programs seem not to have taken these variations in family need into account. It is again the case that failure to meet the particular needs of a family with a young handicapped child may often be the result of the poor co-ordination between agencies; lack of co-ordination may inadvertently create many of the problems faced by such a family. Early intervention programs that omit family support run the risk unintentionally of negating their efficacy by reducing the possibility that program initiatives will be generalized and continued within the family setting; families under stress cannot be expected to implement intervention programs in the home without additional support.

The family is in a unique position during the child's early life to act as an agent of developmental change or, at least, to facilitate the young handicapped child's growth and development. We have noted that while most programs acknowledge this potential family role it is not always fully actualized in practice. There is a pressing need for additional support to the family to enable the father and mother to enact the parenting role not only with the handicapped child but also with his non-handicapped siblings. Relevant agencies at times expect parents to accept the extra work involved in implementing an intervention program without providing the necessary training and support.

Regardless of the approach the different programs have to the roles of parents in their programs, most programs would agree there is a need for more parent relief services. Child-minding services, methods for overcoming transportation problems, financial support, and support for other family members are all issues which parents cite as needing more attention. Differing conceptions of the role of parent as intervenor are discussed in a later section.

There is a need for a philosophy of intervention that recognizes that this is a stressful period for families of young handicapped children, that help must be available to them to maintain those children within their families and that useful developmental programs ought also to be made available. The intensity of parent involvement in early intervention, however, must be sensitively tailored by program staff to the needs, wishes and circumstances of the parents - where parents wish to engage in a very intensive structured program, they should be entitled to do so; but not all parents will desire or be capable of such a level of engagement. If such a policy is to be implemented, there is a need for a range of professionals in the field who are flexible in their approach to parental involvement and committed to the principle of recognizing the importance of parental rights.

The age of children receiving early intervention programs varies considerably. When should intervention commence? Most program staff believe that early intervention should commence as soon as possible after assessment and diagnosis have revealed the existence of the handicapping condition(s). For many children, this is not the case because the services available vary in the extent to which very young children can be accommodated. In some areas, there is an agreed division of the clientele by age across existing agencies. At times this seems to be a somewhat arbitrary division and we have been left with the distinct impression that this situation has led to some unnecessary delays in the provision of the full range of services required by a particular child.

Disability may inadvertently be transformed into handicap because the required services are not available at the earliest possible time. It is an unsatisfactory situation for a child to receive a partial intervention for some aspects of his developmental disability and not others. Health agencies seem in a better position to implement therapy interventions and medical services at a very early age whereas educational provisions are typically delayed until the child is older. This need not be the case. In the vast majority of cases, appropriate educational intervention, at the earliest possible stage, is necessary if the young handicapped child is to be able to explore his environment, interact with others and acquire those skills that will promote the many facets of his development.

A further aspect of clientele in which there is variation among programs is the degree of homogeneity of the group served in respect to handicap. The specialization of services according to disability, as opposed to programs for a diversity of disabilities, seems to be largely historic in origin, and related closely to the differing commencement of services by voluntary organizations and by governments, the former often preceding the latter. More recent patterns that are not related to the historical framework of development are more specifically aligned to the philosophical orientation of the program. Programs committed to a remedial emphasis are most likely to serve a specifically defined disability group and least likely to include programmed integration experiences. In the case of a developmental emphasis, the children served in any one program may share either the one disability or a diversified group of disabilities.

The historical emphasis on homogeneity has probably been reinforced by the tendency of parents of children with the same handicap to gather together and perhaps also by research interests which have tended to focus on'homogeneous'groups. By contrast, the emerging orientation to heterogeneous groups has been fostered by an emphasis on the children and the dimensions of their problems, rather than upon the disability per se, and by the increase in the proportion of the total population of handicapped children who are recognized as multiply handicapped.

The bringing together of differing disability groups, provided the necessary staff expertise is available, may be particularly appropriate to smaller communities. It is neither possible, nor desirable, to avoid categorization of handicapped children. There are, however, concerted efforts currently to replace the traditional categories of handicap with a more specific, developmentally and educationally relevant system of classification.

The issue of integration is relevant here also. Further thought needs to be directed to determining the optimal ratio of handicapped to non-handicapped children in intervention settings; the ratio will be dependent on such variables as the nature and severity of the handicaps, the support services available and the expertise and attitudes of staff. The issue is more complex than merely a decision between integration and segregation; for some children a mix of experiences may be desirable and valuable, some being gained at a regular pre-school or play group and some in a specialized program.

Finally, questions need to be addressed to the adequacy of coverage of intervention services in relation to type and degree of handicap. Tjossem (1976) has defined three categories of vulnerable infants:

(1) infants who appear to be developing in unusual ways related to clearly-diagnosed medical disorders and who thus have *established risk* for delayed development;

(2) infants with depriving life-experiences who are at *environmental risk*; and

(3) infants with an increased probability for delayed or aberrant development after biological insults, who are at *biological risk*, though diagnosis may be difficult or uncertain.

Tjossem notes that, although the above categories are not mutually exclusive, each does have distinctive implications for diagnosis, identification, and intervention strategies. Furthermore, the interactive effects of environmental risk factors with biological risk factors complicate the situation for affected children. Clearly there are differences in the availability of services for these groups. Moreover a cause for concern arises from the often relatively late or difficult diagnosis of minor degrees of disability, such as mild intellectual handicap; such children are disadvantaged because of the operation of one or both of the following:

- those whose parents are also mildly intellectually impaired or emotionally disturbed or threatened by life's circumstances are unlikely to seek intervention services;

- program planners have not typically sought to offer such services to these children, because they believe other groups to be in greater need and/or because they are wary of the dangers of premature, and perhaps incorrect, labelling.

Yet this group of children constitutes the largest single group of children with handicap and appropriately designed early intervention programs could maximize their chances of coping adequately with their world, particularly after school entry.

In other areas of impairment also, those with a mild handicap outnumber those with a moderate, severe or profound handicap and, while their needs may seem less urgent, nevertheless they too can profit from, and deserve access to, early intervention programs.

9.1.3
Program Staff

The issues to be faced here revolve around which professionals or teams of professionals should plan and implement early intervention programs and what should be the roles of volunteer staff and of parents. It seems likely that most situations require personnel with a diversity of attributes. Different circumstances, objectives and/or groups require differing combinations of personnel for the effective functioning of programs.

Before a determination can be made about personnel there needs to be a careful consideration of the required skills; where this does not occur inappropriate expectations are likely to be held of personnel. Not all the required skills are professional; some are within the repertoire of volunteers who, in addition, may constitute better bridges between the handicapped child and the general community than parents or professionals. Yet other skills can be practised by family members, who because of their emotional investment in the handicapped child and/or their extended time with him, are the most appropriate people. Finally, careful consideration needs to be given to the required range of professional skills.

Within the relevant professions, close consideration also should be given to the ways in which traditional disciplinary roles need adjustment to meet the particular requirements of early intervention. Collectively the professions must address the vexatious problem of meshing traditionally separate approaches to service delivery into the concerted team effort that seems essential to the effective early intervention required by children with handicap.

Regardless of the philosophical orientations of programs, the need for multidisciplinary involvement in early intervention is widely acknowledged. In practice, the extent to which the professionals function as a coherent team varies as does the range of professionals involved in any program. It is not always clear whether these variations are a function of the needs of the clientele or, rather, whether they reflect the characteristics of the professional group which happened to be most actively involved with handicapped children at the time of the establishment of that program. Such traditional patterns of involvement may often impede the entry into the field of members of other relevant professions; this is an issue that requires consideration not only by the professionals involved, but also by those in a position to alter policies so as to facilitate the adjustment of the composition of early intervention teams in a manner that maximally relates to client needs.

Utilization of parents as "teachers" or "therapists" raises a number of issues which need to be addressed. The first concerns the extent to which a family can cope - or needs to cope - with the dual burdens of maintaining the family unit while caring for a young handicapped child and being asked to accept responsibility for the implementation of an intervention program. The second is somewhat similar and involves the practice, particularly in some programs administered by voluntary agencies, of expecting such parents to be able, and willing, to devote time and energy to the fund raising role.

The third issue relates to whether it is reasonable to expect parents to have the skills required of intervenors. Some parents may be able to perform all of these roles; others may accept the roles, unable to admit in their diffidence that these are beyond their competence or capacity; still others will express clearly their refusal to be so involved. Acceptance of the "teacher" or "therapist" role by the parent should not be the price of admission of a handicapped child into a program and, in endorsing the principle of parental involvement, professionals should be careful lest in their enthusiasm they inadvertently ignore the realities of each family's circumstances. It cannot be assumed that professionals will have within their armoury of expertise the skills involved in assessing these circumstances. Sensitivity to both the resources available within a family and the limitations of the family members would seem to be an essential attribute of staff.

9.2
PROGRAM ISSUES

The philosophical orientation of a program tends to influence the type of program that is developed. Program differences relate particularly to the issues discussed above: the extent to which a program provides for one disability group or several; whether it is a comprehensive program or specialized in some area such as language development or sensorimotor stimulation; whether it includes opportunity for integrated experiences with non-handicapped children; and the extent to which families receive support and/or parents are involved in the implementation of the program.

9.2.1
Program Content

The extent to which program content is decided by one professional or by a team of professionals varies from program to program, according both to the composition of staff and the responsibilities assigned to staff members. Where an individual bears the responsibility for program design the issue becomes one of the breadth of the ensuing program; awareness of the other programs which may be concurrently serving the child's needs is essential. Where the task is shared by a team, the issue is one of co-ordination and the attainment of a balance of the diverse objectives of the program components. In the latter case, the process of program development is complicated by the existence of the quite different philosophical orientations of staff; team members must be prepared to agree on broad program objectives and then work to ensure that their specific approaches are consistent with the overall program goals. In either case, mechanisms need to be established to facilitate communication both amongst staff members and between staff and parents.

Programs are not necessarily decided by staff alone. Indeed, it may strengthen a program to have the children's parents involved in the determination of their learning experiences; such a procedure also recognizes the rights of the parents. Again, involvement of parents in the process of program design may not be without problems. The traditional expectation of some staff that parents will not be involved in shaping the program will take some time to be modified and, similarly, parents' expectations that the task can be left to the professionals may persist.

Where home-based programs involving parents are operating, the functional relationship between parents and staff takes on a special significance. The frequency of staff visits to monitor parent-implemented programs will be a major determinant of the program outcomes. Too frequent visits may make the parents feel they are too little trusted or that they have no essential role to play. Infrequent visits make monitoring of the program superficial and this militates against effective modification of the content; there is a high risk not only that the program will be ill-defined, but that parental anxieties may be exacerbated by the feeling of uncertainty inherent in implementing a program in the absence of regular feedback for the professionals responsible for the program's design.

The press for integration similarly raises issues related to the extent to which associated staff working in regular settings will be involved in the process of program development for the period the child spends in early intervention. Whether involved in program design or not, such staff need to face the perplexing issue of their possible involvement in implementing aspects of the special program in their own setting. The degree to which they are competent to do this and their need for support are matters on which policy makers must reflect. Some handicapped children, as we have seen in our survey, are enrolled in more than one program; sometimes this involves a number of special placements and sometimes a combination of regular and special enrolments. How effective are such multiple enrolments in the absence of any mechanisms of co-ordination?

One of the major impediments to co-ordination may be the differences in staff practices in the recording of program information. Educationalists tend to see a need for an explicitly formulated curriculum recording relatively detailed short-term goals and long-term objectives. The outcome of efforts to achieve each goal may also be carefully recorded. Therapists are perhaps more likely to record detailed diagnostic information and more general guidelines for treatment. The two sets of records may be difficult to inter-connect, thus reducing the extent to which the intervention efforts of each group can be co-ordinated.

When the programs of a number of intervenors are co-ordinated, complementary and even reinforcing interventions can be organized instead of the traditionally isolated efforts of the various disciplines. In this way, the efforts of one discipline can be continued in the implementation of aspects of the program designed by other staff.

Difficulties may arise when early intervention services adopt packaged programs typically developed overseas. These programs may have been developed in a distinctive socio-political context where the implicit assumptions produce program goals and strategies not easily transportable to the Australian scene. An important development within some Australian tertiary institutions has been the effort to modify such programs in a way that tailors them to the special requirements and prevailing Zeitgeist of early intervention in this country. Initiatives in the development of original programs have, in general, lagged somewhat behind. The need to ensure that there are programs, either locally derived or locally modified, must be recognized and appropriate resources mobilized; funding bodies could well regard such research and development as a high priority at this stage in the evolution of early intervention in Australia.

9.2.2
The Role of Assessment

The development of an early intervention program for a young handicapped child is fundamentally dependent upon the available assessment information about the child and his disability. This will not only direct the initial formulation of the program but will also serve to inform staff on the ways in which the program will require ongoing modification. There is, accordingly, an important need for systematic communication of assessment information among those concurrently involved with the child's welfare. Where programs are individually designed, the need is for transmission of any relevant information from the other professionals who have previously assessed the child to the staff of the current program. Where the program is developed by a team of professionals, effective communication requires that each team member transmit assessment information in a form that can be readily understood by his colleagues. These staff also need to be fully cognizant of earlier assessments of the child. In practice, such communication networks have often developed in an ad hoc manner; a more systematic approach would provide a more informed context for program development and, moreover, would overcome any difficulties arising from staff turnover. At present, the network is only as strong as the set of individuals who fortuitously coalesce in their concern for a particular child.

Problems of transportability also apply to assessment instruments, many of which have been developed in conjunction with overseas intervention programs. Again, research and development are urgently required in this area. The dearth of appropriate instruments has far-reaching implications for both program development and the evaluation of program outcomes. The latter issue is examined in detail later in this chapter.

The nature of assessment also varies as a result of the general orientation of program staff to the role of intervention vis-a-vis the development of the young handicapped child. Programs with a remedial emphasis may place stress upon the assessment of a relatively restricted set of achievements by the child. In contrast, those programs with a developmental orientation may strive for a much broader assessment. In the former emphasis, task-specific assessments may predominate; in the latter, the use of developmental checklists covering an array of attainments not necessarily linked directly to the program is more typical. Remedial programs may err in overemphasizing specific, narrow attainments while in the case of developmental programs the error may lie in assessing general achievements, not all of which can be clearly linked to program content. In either case, the match between the scope of assessment and the intervention is often rendered less than perfect by limitations in current application of theories of assessment, of development and of intervention.

The place of formal and informal assessments in early intervention is a further contentious issue. Some professionals express doubts about the utility of formal assessments that are difficult to relate to program content; others see a danger in over dependence upon informal, often anecdotal assessments of a child's developmental status and progress. A balanced mixture would capitalize on the virtues of each approach.

The information on their children provided by parents is sometimes unnecessarily devalued by staff. Yet staff are in need of such information. Unlike staff, parents have the opportunity to see the child behaving in the complex and unpredictable environment of his home and community. Not only is it the case that full profit is not extracted from the parent's knowledge, but also parents may be deprived of sharing in staff understandings of their children through the imperfect transmission of relevant information. In many cases staff may be inadequately trained to impart assessment information to parents. Where staff are adequately equipped to share their understanding both with other professionals and with the child's parents, the mechanisms for such information exchange may vary in the efficiency of their operation. There is a manifest danger that information exchange may be fragmented and uncoordinated. Such a situation can lead to the transmission to the parents of conflicting impressions of the child and his handicap by the various people seeing the child. Unresolved inconsistencies in the information transmitted to parents can create unnecessary anxieties for them. There is clearly a need for better case co-ordination structures. Regular case conferences are one solution to this problem. However, in developing this structure, in whatever form is most appropriate to a particular program, staff should recognize the central role of a case co-ordinator, responsible not only for linking the various assessments but also for communicating a balanced and consistent picture to parents.

The extent to which assessment information is recorded varies across programs. It is likely that programs within the remedial orientation will emphasize detailed recording. This in part reflects the nature of the preferred assessment procedures in these types of programs. In programs generally, however, staff complain of the difficulties of keeping detailed records of child progress and simultaneously implementing their programs.

9.2.3
Monitoring Programs

Just as the time available for assessment and record keeping is limited, program staff may lack both the time and the expertise to monitor the efficacy of their program systematically.

One of the most striking features of the current scene is the relative absence of evaluation in the majority of programs. In terms of the uncertainties in the area and the recognized need to monitor progress and evaluate outcomes in order to provide information about the effectiveness of programs, this is unexpected. However, when staff backgrounds and work loads, the general lack of clerical support staff, and the exigencies of day-to-day program implementation are considered, the situation becomes more understandable. Both staff and administrators are aware of the problem but uncertain as to how to address it. Any rapidly growing new area in the provision of services is likely to produce such difficulties. This is clearly an area that requires close attention in the immediate future.

Staff evaluation of program outcomes is often rendered difficult by the lack of clearly formulated program objectives. Again, the program emphasis will determine the level of specificity. In remedial programs, as suggested earlier, the objectives may be framed in terms of specific behavioural attainments or the acquisition of a set of specific skills. Developmental programs, on the other hand, may have much broader sets of objectives. These differences reflect the quite different positions within each emphasis with regard to theories of the young handicapped child's development and the processes of intervention in the developmental course.

The children's achievement of highly specific objectives may be readily evaluated, at least in the short term. Those working within the developmental emphasis are likely, however, to suggest that such short term demonstrations of program effects cast little light on the extent to which the developmental course of the child is altered in the long run. Our limited current state of knowledge of the varied developmental implications of the wide range of disabilities impedes resolution of this dilemma. It is difficult to provide guidelines for program evaluation when there is lack of consensus on the desired outcomes. This further emphasizes the emergent status of early intervention and signals the danger, at this stage, of expecting agreement when so many of the basic issues are still imperfectly formulated.

The absence of detailed records of children's progress evident in many programs - the result of time and staffing problems discussed earlier - makes monitoring of program outcomes, however defined, a difficult task and one, moreover, to which such program staff are unlikely to accord high priority. It is not surprising that an even lower priority is often assigned to recording the details of ongoing program implementation. This situation makes process evaluation all the more difficult to undertake. Program staff not infrequently turn to researchers for assistance in monitoring their program effectiveness. The ability of the latter to respond to such requests is limited by the lack of systematic records of program details. A solution to this difficulty is not easy since funds available to programs typically preclude the employment of sufficient staff to undertake this time-consuming but essential task.

While the problems of how best to monitor child outcomes are difficult to resolve, a more perplexing set of problems concerns the evaluation of the wider impact of programs, such as:

- the effects of participation in the program upon the family - their perception of the child and of the efficacy of his program;
- the impact of the program on community attitudes towards and knowledge of children with handicap;
- the effectiveness with which the program is articulated with other relevant services.

A major and as yet unresolved issue of concern to program staff, parents and researchers alike is the appropriate evaluation of the qualitative aspects of programs. Attempts at quantification, though necessary, may unintentionally direct attention from the subtle and yet highly salient aspects of a program's efficacy which at this stage in the development of the social sciences seem to defy precise specification and measurement. It is all too easy to over-simplify the task of evaluation and to be satisfied with assessments which, in concentrating on the narrow, readily quantified aspects, neglect the less tangible moderating variables and in consequence fail to explore the total contribution of the program to the well being of the children, their families and the wider community.

9.3
SERVICE DELIVERY SYSTEM

There are issues of significance in the provision of early intervention services which transcend those germane to individual programs; these are issues related to the way in which services are planned and developed within towns, cities, regions, states and the nation at large. Key issues include the following:

- determination of the pattern of prevalence and provision for all in need,
- the locus of responsibility for provision of services and their co-ordination, and
- the special situation of rural areas.

Resources to meet the needs for early intervention are inevitably more limited than advocates would desire. Furthermore, the cost of services is differential according to the location, the type and severity of handicap and the age of the child. Accordingly, there is a pressing need for co-ordination and for rationalization of services to ensure the most effective return from the monies invested in this area and to extend the accessibility of services to young handicapped children and their families.

9.3.1
Prevalence and Provision

The provision of services in Australia may not reflect the pattern of prevalence of handicap. The ad hoc evolution of services has inevitably led to an imbalance, with some areas offered multiple services while other areas suffer relative neglect. One major difficulty facing those who would seek to plan for rationalization of services lies in the fact that in this, as in so many other areas, there has been an almost crippling lack of information on the prevalence of the various types of disabling conditions in the population of young children. This lack could be overcome by the establishment of an "at-risk" register.(1) There are attendant difficulties, however, in the compilation of such a register. Firstly, early identification can be problematic as a result of both the nature and time of manifestation of many developmental disabilities, and the current limitations of assessment techniques and instruments already discussed. The effects of these two factors are compounded when the child suffers a mild disability. Furthermore, there has not been development of instruments sensitive to cultural variations for the identification of "at-risk" children from minority cultures within Australia.

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(1) While there have been recent studies of prevalence of disabilities e.g. Appendix L and "Survey of Handicapped Persons, Australia" (ABS Cat. No. 4342.0), the determination of relationships between these figures and changing patterns of services and disabled populations is still critical.

Secondly, early identification ought to be tentative and assessment should be ongoing, with initial diagnoses subject to a process of verification at regular intervals. The resources necessary for undertaking the task of reviewing the "at-risk" status of the children are severely limited. Solution of this problem would require both additional resources and the better utilization of existing resources. In the absence of effective review procedures, the incidence of mis-classification of children cannot be determined; where such errors occur, a child's future may be prejudiced.

Thirdly, the establishment of such a register carries with it the moral obligation to provide adequate services to meet the implied needs of the children. Variations in the ability of assessment services to meet this need may result in little more than the screening of children without appropriately intensive assessment. In the current state of the art the results of such screening may often be suspect. Finally, the instruments available for screening may be insensitive to the less severe and non-organic disabling conditions characteristic of a large proportion of the children potentially requiring early intervention; thus they may not be included in the register.

Despite these very real difficulties, planning for the adequate provision of intervention services requires the availability of estimates of incidence; the promise of provision of services implicit in the gathering of data for an "at-risk" register would need, of course, to be honoured. The federal government would appear to be the logical catalyst for the initiation of such a register.

Once accurate estimates of prevalence are available, well-informed assessments of the needs of families can proceed. In the past, needs assessments have been unavoidably piecemeal and present patterns are therefore an inadequate reflection of both prevalence and need.

Some indication of the probable scope of the prevalence of disabilities among the infant, toddler and pre-school aged population can be derived by extrapolation from the incidence figures for the population of older children.

Based on June, 1978 demographic estimates, there were 1,421,600 children in Australia aged five years or younger (ABS Cat. No. 3201.0). In the same year, 3,011,673 students were enrolled in Australian schools

(ABS Cat. No. 4201.0); of these, 108,000 (3.58%) were estimated to have a handicapping condition (Andrews et al. 1980).*

Using this prevalence estimate on children aged five years or younger, approximately 50,000 children can be considered candidates for early intervention programs. Many of these, of course, will not be identified as possible candidates for early intervention services at young ages, although conversely there will be children identified as needing services at a young age who no longer require them at school age (e.g. low birth weight, small for age).

Our data reported in Chapter 5 on 133 programs (87% of the estimated population of programs) indicate that 5,157 children are receiving early intervention services. Thus there appears to be a large number of children, over 40,000, who may need, but do not receive, an early intervention service. Our survey does not allow us to know whether their needs are met in other ways, e.g. through regular pre-schools, day care centres, or medical and paramedical services.

9.3.2
Sponsorship, Responsibility and the Co-ordination of Services

Viewed nationally, the patterns of sponsorship of programs and responsibility for their administration and implementation show an extremely complex mixture of involvements of government - federal, state and, to a lesser extent, local - and voluntary organizations. While initiatives are in train in several states to co-ordinate the sponsorship of and responsibility for existing programs, there is as yet no clear assumption of responsibility. This situation has a high probability of first, leaving gaps in provision unfilled and second, leaving many programs in the position of facing, from year to year, an uncertain future. The latter circumstance carries with it low staff morale and heightened family anxieties. The former perpetuates the inequities in service provision across both disability groupings and geographical regions.

The reform of this fragmented pattern of responsibility must be an urgent priority, if it is accepted that the availability of high quality early intervention programs is an essential community service. The current reality is that governments are the major sponsors of early intervention initiatives; to date they have played their role by responding to requests for support from various groups within the community. The assumption of government responsibility for provisions for all handicapped children and their families is still a matter of some contention. Some voluntary agencies see a virtue in maintaining the status quo, continuing to exercise their responsibility but acknowledging their need - indeed, their growing need - for government subsidy. The difficulty with this position is that, given the economic realities, voluntary agencies are in many cases not able to extend their services to the areas currently experiencing unmet needs. Ironically, there is an expectation that the responsibility for filling such gaps will reside with the governments, a situation that is less than tolerable for the families deprived of services.

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* ANDREWS, R.J., ELKINS, J. BERRY, P.B., and BURGE, J.A. A survey of special education in Australia: Provisions, needs and priorities in the education of children with handicaps and learning difficulties. Canberra: Schools Commission, 1980.

A further irony is that governments are impeded in progressing towards extended exercise of their responsibility by the traditional divisions between departments and agencies at both state and federal levels. In practice, this may be the result of the existence of very different perceptions of function and distinctive modes of service delivery. The success of government efforts is in places hindered by the existence of differing administrative structures and idiosyncratic approaches to regionalization. As we noted in Chapter 4, several of the states have established interdepartmental steering committees, consisting predominantly of senior representatives of education, health and welfare departments, to examine ways of overcoming the barriers currently frustrating the efforts at co-ordination.

Attempts at co-ordination may not necessarily involve reduction in the number and variety of programs serving the needs of a particular group. Sensitivity to the complementarity of different programs, each ostensibly directed to meeting the needs of a particular group of handicapped children, should be an attribute of those charged with the task of rationalizing services. A measure of freedom of choice must exist in order to enable parents to exercise their right to seek the program which they believe will best meet the family's needs. Awareness of unnecessary duplication must coexist with this sensitivity.

Recent government initiatives, particularly within some education departments, have been directed to bridging the gap between established programs for children with easily-classified disabilities and the regular services available throughout the community. The impetus for this has been, in part, awareness of the need to accommodate the comparatively large group of children with less severe and/or less easily identified handicaps. This has in fact extended the diversity of offerings. Thus some parents may in principle seek to place their child in all three settings, in two, or in one. In the former cases, as we have discussed earlier, the success of the placements will be to some degree dependent upon effective communication among program staff, and between staff and parents. There is accordingly much greater opportunity for mobility of children between placements but capitalization on this opportunity depends on the existence of effective mechanisms of cross-referrals and the exchange of information about children.

In theory, this diversity should open a range of avenues for placement of the child following his initial enrolment in an early intervention program. In practice, however, our survey has indicated that in some regions intervention staff still show a predilection for traditional avenues of placement. Those seeking better co-ordination at the system level will need to consider explicit ways of capitalizing on the emerging potential for flexibility. The ad hoc links between the various modes of early intervention service delivery established by those at the work face perhaps need formalized mechanisms to facilitate their more general application.

Access to programs may also depend on somewhat ad hoc sets of arrangements for transporting children to and from programs; there are marked differences in this regard. Many programs rely upon volunteer drivers or parents' private transport and, in some cases, children are selected for programs only if transport can be provided by the parents. This effectively constitutes a selection factor for access to these programs. Some programs provided by voluntary agencies overcome this by use of buses for children whose parents cannot provide transport.

Program staff do not always fully appreciate the complete set of problems parents face in transporting their children not only to the program with which they are involved but also to the other programs and/or services that these children require. Governments could turn their attention to the issue of how best to provide transport assistance and/or how to organize related services in centralized locations. In facilitating the provision of transport, attention may well be paid to the possibilities of assigning to appropriate departmental officers the task of organizing pools of private transport, or the provision of wider access to existing transport systems.

The issue of transport is relevant also to the form of service delivery offered by programs. Often the type of funding for a program makes it difficult for staff to visit the homes and the program is forced into being centre-based when sometimes greater flexibility for home visiting would be preferred by staff and families.

Transport problems become even more serious impediments to program access and delivery in rural settings where distance and limited population exert their tyrannical influence. In most areas of Australia attempts have been made to offer early intervention to rural handicapped children and their families. Limitations of finance and of personnel create a situation in many rural areas of considerably reduced availability of early intervention services. Even were finance to be increased, it would still be difficult in many areas to secure the services of sufficient professionals to mount an itinerant scheme. Where such schemes are currently operating, program staff have severely limited time to spend with each of their clients, given the constraints of travel time and the distance to be covered. Centralized service delivery agencies may find that it is possible to achieve greater efficiency by co-ordinating itinerant services within a given region where a number of agencies may provide complementary but separate program staff. In provincial centres, local authorities may need to mobilize available services to supplement the limited and/or infrequent access to the itinerant staff.

A few tertiary institutions have become catalysts for the process of exploring ways in which the particular problems of service provisions in rural settings may be overcome. This is but one facet of the involvement of a small number of tertiary staff in early intervention. The importance of early intervention and the breadth of need warrant a greater investment of research and development effort. Support of model programs, such as those established at these universities and colleges of advanced education, is an important priority. However, care needs to be exercised to insure that such programs do not become entrenched alternative services for small groups of children. Their responsibilities are perhaps most clearly in the areas of program trial and development and staff training, as well as a continuing contribution to basic and applied research.

As early intervention is an emergent area of service delivery, we typically find that staff of programs have not had the opportunity to undergo specialist training for their roles. If early intervention programs are to make their maximum contribution to the development of children with disabilities, the issue of staff is one which must be addressed. In a number of professions, specialist training is often achieved through the offering of in-service programs to people already trained in their basic discipline. This in-service training may be achieved either through short intensive courses or part-time study over a longer period. The in-service approach may be an appropriate route to the necessary insights and skills but it suffers from at least two disadvantages. First, engagement with young handicapped children and their families is highly demanding, and part-time study at the end of the day may be impracticable. Second, because of the newness of many facets of the early intervention enterprise there is not a strong body of established expertise in many agencies to use as a basis for in-service training.

It would seem, then, that thought might be given to the desirability of establishing an alternative approach: post-graduate courses. Because of the nature of the team work in which they will subsequently be engaged, it would seem desirable for members of all the relevant disciplines jointly to participate in such a course. The detailed components of the course could only be decided in the light of experience, but comments from the field would indicate the desirability of including study and supervised experience in at least the following areas: early child development, handicapping conditions, program development and implementation, assessment, team membership, the consultant role, parent support, the roles of parents in programs, and a broad knowledge of the range of programs and their associated theoretical positions.

A cognate issue is the staffing of such training courses. Again the relative newness of the field means that comparatively few academics have the appropriate training and expertise to teach such courses. Steps may well have to be taken to foster the development of a corps of lecturers.

It may well be that there are other ways of ensuring that intervention programs will be staffed by qualified people; this is an issue that warrants consideration by all concerned. For example, there may be merit in developing a program to provide technical assistance and leadership training, or setting up a series of task forces or even considering modifications to initial courses of professional preparation for teachers and therapists. In this matter, as in every issue we have considered, there is need for diversity, provided only that quality is the hallmark of each alternative.

Basic to issues of quality are matters of funding. Our review has provided a picture of the complexity of funding currently available to early intervention programs. Despite this complexity, several issues concerning funding can be clearly delineated. Firstly, the bulk of financial support appears to be directed to program operation. Secondly, there are a number of other facets of the service delivery context that are in need of much greater support. The relative neglect of three areas in particular may jeopardize the effective implementation and further developments of early intervention services; these three areas are: staff training, support services and program evaluation.

In addition, there is still an unmet need for a thoroughgoing evaluation of the economics of providing appropriate and effective service delivery systems throughout Australia. This is a further priority area.

9.4

ONGOING RESEARCH AND EVALUATION

The complexity of early intervention makes ongoing research in the area an urgent priority. At present there is no single approach or orientation to early intervention, nor is it possible to identify a single optimum program. Rather, programs are dynamic entities affected by the setting, the attributes of staff, the characteristics of the clientele and the wider community context in which the program is set. All these variables complexly affect the nature of early intervention in a particular location. This individuality of programs, settings, staff and children makes simple comparisons very difficult. To demonstrate that a program is effective with one group of children, with one set of staff, in one setting, is not a sufficient basis for predicting that that program will be effective system-wide.

The situation is further complicated by the problems of identifying the salient elements in any program demonstrated to be effective. It is not simply the content or the method of delivery that results in efficacy. Rather, the value of a program is the product of a complex mix of factors. As previously suggested, parental perceptions and attitudes, for example, may be as important as the content or methods of delivery.

The complexity of early intervention, coupled with our inadequate knowledge of many of the aspects of child development and handicap, make evaluation an even more difficult task. As suggested above, in the absence of consensus on appropriate methodology and the measures to be used in such research, it is difficult to be definitive with regard to the future course of research on early intervention programs. Early intervention is inherently an evolving entity. This apparently simple insight must shape our perception of the exercise of evaluation in this area. The rapidly changing face of early intervention often makes summative procedures inappropriate and evaluators must rest content, for the time being, to be essentially descriptive of the process of program evolution. Rigorous description is a legitimate and essential part of the researcher's contribution to the evolution of early intervention. Premature attempts to provide summative evaluations might only result in a grossly over-simplified view of the field.

Over-simplification may in turn promote restricted conceptual models of the nature of early intervention and, as such, be of limited heuristic value. We need three research foci. First, concerted programs of basic research must examine the particular developmental implications of each of the wide range of disabilities which will benefit from early intervention. Basic research will provide the enriched theoretical context required to inform program designers. Second, more research is needed which has as its basic aim the detailed description of the development of particular programs with a view to identifying the range of potentially influential factors contributing to the efficacy of early intervention. Third, in conjunction with these two foci, basic researchers need to consider ways in which they can capitalize upon the interaction among program designers, program implementers and those addressing the methodological problems of evaluating ongoing programs. While basic researchers, designers, implementers and evaluators proceed in isolation from one another, research efforts in the area of early intervention will remain disjointed.

At this stage researchers should be clearly aware of the need to adjust the direction of their efforts in response to the inevitably rapid changes in the field. This is, in part, the result of the differences in the rates of change of our basic knowledge and of our practices in the field. As early intervention programs develop they must of necessity respond to changes both in the field and in our knowledge of the clients, changes which in fact occur at a rate which often outstrips the ability of researchers to frame proposals, secure funding and execute their research.

Notwithstanding the rapid expansion of programs, it must be realized that this growth has occurred in the absence of systematic assessment of the full range of unmet needs existing in the community. Accordingly, an equally urgent need is the undertaking of such systematic assessments at national, state and regional levels in order to be a position to work towards rational service provision.

The current review represents the first stage of the process of evaluating early intervention services in Australia. It provides the first systematic map of the national scene and, as such, gives a basis upon which researchers, program designers, program implementers and evaluators can continue their vitally important work.

RECOMMENDATIONS

1\.

Register of Children

In recognition of the need for adequate information on the prevalence and distribution of disabilities of varying type and degree to provide a basis for the realistic planning of services for young children with disabilities,

IT IS RECOMMENDED

- THAT REGISTERS OF CHILDREN WITH IDENTIFIABLE DISABILITY OF WHATEVER DEGREE BE ESTABLISHED AS A MATTER OF URGENCY, DUE CARE BEING TAKEN TO MINIMIZE DISADVANTAGES POTENTIALLY ASSOCIATED WITH SUCH REGISTERS,

- THAT THE STATISTICAL DATA FROM SUCH REGISTERS BE MADE AVAILABLE TO RELEVANT DEPARTMENTS AND AGENCIES, AND

- THAT A MECHANISM BE ESTABLISHED TO ENSURE THAT SUCH REGISTERS ARE CONSTANTLY UPDATED.

2\.

Provision for all

In recognition of the rights of all children with disabilities and their families to receive appropriate educational services from as early an age as a disability is diagnosed, and in recognition of the extensity of unmet needs in the community, with consequent detrimental effects on the development of young children with disabilities and major stresses on their families,

IT IS RECOMMENDED

- THAT GOVERNMENTS RECOGNISE THEIR RESPONSIBILITY TO ENSURE THAT ALL YOUNG CHILDREN WITH DISABILITY HAVE ACCESS TO EARLY INTERVENTION PROGRAMS, AND

- THAT FORWARD GOVERNMENT PLANNING MAKE PROVISION FOR SUCH PROGRAMS, INCLUDING THE SUPPORT SERVICES REQUIRED FOR THEIR EFFECTIVE IMPLEMENTATION AND TAKE COGNISANCE OF ISSUES RELATING TO THE SITING OF SERVICES.

3\.

Diversity of needs and of programs

In recognition of the diversity of needs of children with disabilities and of their families, and in recognition of our as yet incomplete understanding of the development of young exceptional children, and in recognition of the emergent status of early intervention programs,

IT IS RECOMMENDED

- THAT FUNDING AUTHORITIES AND RESPONSIBLE AGENCIES SUPPORT A DIVERSITY OF TYPES OF EARLY INTERVENTION PROGRAMS.

4.

Families

In recognition of the central role of the family and of the needs of the family as a unit and in recognition of the differing characteristics and circumstances of families, and the current philosophy of deinstitutionalization and the home care of children with severe disabilities,

IT IS RECOMMENDED

- THAT EARLY INTERVENTION PROGRAMS ENSURE OPPORTUNITY FOR PARENTAL INPUT, AND
- THAT SERVICES TO YOUNG CHILDREN WITH DISABILITY INCLUDE, WHERE FAMILIES SO DESIRE, PARENTAL RELIEF, FAMILY SUPPORT, BOTH PROFESSIONAL AND MATERIAL, AND ASSISTANCE WITH TRANSPORT.

5.

Coordination of services

In recognition of the dependence of program effectiveness on the planned articulation and coordination of services,

IT IS RECOMMENDED

- THAT, AT NATIONAL, STATE, REGIONAL AND LOCAL LEVELS, MECHANISMS BE ESTABLISHED TO ENSURE
  - THAT THERE IS EFFECTIVE COMMUNICATION AMONG THOSE RESPONSIBLE FOR EARLY INTERVENTION PROGRAMS WITHIN THE ONE AREA,
  - THAT EARLY INTERVENTION PROGRAMS ARE COORDINATED WITH OTHER SERVICES TO YOUNG CHILDREN WITH DISABILITIES
  - THAT EARLY INTERVENTION PROGRAMS ARE COORDINATED WITH GENERIC SERVICES FOR ALL YOUNG CHILDREN, AND
  - THAT EARLY INTERVENTION PROGRAMS ARE ARTICULATED WITH LATER EDUCATIONAL SERVICES.

6.

Rural Families

In recognition of the dearth of services to young children with disabilities and their families, in rural areas, and in recognition of the challenges imposed both by the existence of small numbers of children with particular disabilities and by the limited services from relevant agencies in any particular area,

IT IS RECOMMENDED

- THAT URGENT CONSIDERATION BE GIVEN TO WAYS IN WHICH EARLY INTERVENTION PROGRAMS CAN BE OFFERED TO YOUNG RURAL CHILDREN, AND

6. (cont.)

Rural Families

- THAT AGENCIES AND DEPARTMENTS BE ENCOURAGED TO EXPERIMENT WITH INNOVATIVE WAYS OF OFFERING THROUGH ONE AGENCY OR DEPARTMENT THE DIVERSITY OF SERVICES NEEDED BY FAMILIES WITH YOUNG CHILDREN WITH DISABILITY.

7.

Monitoring and Evaluation

In recognition of the principles of accountability in the expenditure of public funds and of moral accountability to children and their families, *but* at the same time,

In recognition of the methodological and interpretative dilemmas integral to the evolution of early intervention programs and of the emergent nature both of programs and of paradigms of evaluation, and

In recognition of the need to extend our understanding of the potentials and limitations of early intervention programs and the nature of support necessary for their effective implementation,

IT IS RECOMMENDED

- THAT EACH EARLY INTERVENTION PROGRAM STATE CLEARLY AND PUBLICISE ITS OBJECTIVES,
- THAT EACH PROGRAM BE MONITORED IN THE LIGHT OF THE FULL RANGE OF ITS STATED OBJECTIVES AND THE OUTCOMES BOTH PLANNED AND UNPLANNED, AND
- THAT THERE BE RIGOROUS DESCRIPTION AND DOCUMENTATION OF THE CLIENTELE AND THE IMPLEMENTATION OF EACH EARLY INTERVENTION PROGRAM.

8.

Tertiary Institutions

In recognition of the critical contributions to the further development of early intervention programs required of tertiary institutions, but also

In recognition of the need for ongoing early intervention programs to be integrated into the full range of services to the general population and the population of those with disability,

IT IS RECOMMENDED

- THAT TERTIARY INSTITUTIONS WITH THE APPROPRIATE EXPERTISE BE ENCOURAGED

  (a) TO INAUGURATE PROGRAMS (EITHER LOCALLY DERIVED OR LOCALLY MODIFIED) TO TEST THEIR EFFECTIVENESS BUT, AT THE APPROPRIATE TIME, TO PASS THE CARRIAGE OF THE PROGRAM TO A RELEVANT DEPARTMENT OR AGENCY,

8. (cont.) *Tertiary Institutions*

(b) TO UNDERTAKE DEVELOPMENT AND VALIDATION OF THE WIDE RANGE OF ASSESSMENT INSTRUMENTS WHICH ARE URGENTLY REQUIRED FOR DIAGNOSIS, FOR PROGRAM PLANNING AND FOR MONITORING,

(c) TO ENGAGE IN THE RESEARCH AND DEVELOPMENT REQUIRED FOR THE PROVISION OF A RANGE OF APPROPRIATE RESOURCE MATERIALS,

(d) TO MOUNT LONGITUDINAL STUDIES OF YOUNG CHILDREN WITH DISABILITIES AND THEIR FAMILIES IN ORDER TO ASSIST IN THE DEVELOPMENT OF THEORIES OF EXCEPTIONAL CHILD DEVELOPMENT AND OF EDUCATIONAL INTERVENTION, AND

(e) TO OFFER THE ESSENTIAL POST-GRADUATE AND INSERVICE EDUCATION REQUIRED BY THE RANGE OF PROFESSIONALS INVOLVED IN EARLY INTERVENTION, IN ORDER TO FOSTER THE DEVELOPMENT OF THE REQUISITE SKILLS, PARTICULARLY THOSE INVOLVED IN THE TEAMWORK REQUIRED IN EARLY INTERVENTION.

9. *Funding*

In recognition of current limitations of government finance for initiatives and in the light of Recommendation 2 above,

IT IS RECOMMENDED

THAT FUNDING AGENCIES EXAMINE EACH REQUEST FOR ASSISTANCE IN THE LIGHT OF THE SERVICES CURRENTLY AVAILABLE IN THE AREA CONCERNED, AND FUND ONLY THOSE SERVICES WHICH WILL BEST OVERCOME EXISTING DEFICIENCIES (EITHER QUALITATIVE OR QUANTITATIVE) IN THE AVAILABLE RANGE OF SERVICES.

- THAT FUNDING AGENCIES ENSURE THAT PROGRAMS WHICH ARE FUNDED ARE ADEQUATELY STAFFED TO FACILITATE THE ACHIEVEMENT OF THEIR STATED OBJECTIVES, AND
- THAT GOVERNMENT SPECIFY A CERTAIN PROPORTION OF FUNDS ALLOCATED TO EARLY INTERVENTION TO BE SPENT ON SEEDING EXPERIMENTAL PROGRAMS OR NEW APPROACHES TO SERVICE DELIVERY FOR A SPECIFIED PERIOD OF NOT LESS THAN TWO YEARS, WITH THE INTENTION THAT, FOLLOWING THE EXPLORATORY PHASE, THE PARTICULAR PROGRAM OR SERVICE WILL BE FUNDED WITHIN THE NORMAL PROVISIONS.

10.

Dissemination

In recognition of the burgeoning status of early intervention programs and the exciting innovations being undertaken in diverse parts of the country, and in recognition of the absence of any central clearing-house,

IT IS RECOMMENDED

- THAT DISSEMINATION OF INFORMATION ON EARLY INTERVENTION AND MECHANISMS FOR SHARING EXPERIENCES BE ENCOURAGED AND SUPPORTED.

APPENDIX A

SITE-VISITED PROGRAMS

Approximately fifty programs were visited by a research team collecting information and observing activities. Visits ranged from brief interviews of an hour or two to visits for a full day or longer. Visits were made to programs serving all disability groups and to government, voluntary, and other types of services. Some visited programs were not included in the data analysis for such reasons as currently non-operational status or emphasis on assessment, treatment, or indirect services to children with disabilities.

The research team was most grateful for the time offered by staff of these programs and their willingness to provide detailed information.

New South Wales

Allowah Babies' Hospital (Private - diverse disabilities, intellectual predominant)

Early Education Clinic (Private - diverse disabilities. intellectual predominant)

Intellectually and Physically Handicapped Children's Association (Voluntary - multiple disability, intellectual predominant)

Hoxton Park School
Bambi Nursing Home

Macquarie University (Tertiary - intellectual disability, all Down's syndrome)

Marsden Hospital (Health - diverse disabilities, intellectual predominant)

Newcastle College of Advanced Education (Tertiary - diverse disabilities, intellectual predominant)

Royal Blind Society (Voluntary - visual impairment)

Sub-Normal Children's Welfare Association (Voluntary - diverse disabilities, intellectual predominant)

The Shepherd Centre (Voluntary - hearing impairment)

Youth and Community Services (Welfare - diverse disabilities)

New South Wales Society for Crippled Children (Voluntary)

Victoria

EPIC (Tertiary - diverse disabilities, predominantly intellectual)

Royal Children's Hospital (Health - diverse disabilities)

Royal Victorian Institute for the Blind (Voluntary - visual impairment)

Shannon Park Spastic Centre (Voluntary - diverse disabilities, predominantly intellectual at present)

Queensland

Autistic Centre (Voluntary - autism)

Central Assessment Clinic (Health - diverse disabilities, predominantly intellectual)

Education Department Pilot Early Intervention Programs (Education - diverse disabilities, predominantly intellectual)

Aspley
Ipswich
Kenmore
Mt. Gravatt
Acacia Ridge

Multicap Association, Toowoomba (Voluntary - multiple disability)

Sub-Normal Children's Welfare Association (Voluntary - intellectual disability)

Toowong
Main Centre

South Australia

Adelaide Children's Hospital (Health - diverse disabilities)

Autistic Children's Centre (Voluntary - autism, with multiple disability and others represented)

Infant Development Project (Private - diverse disabilities, predominantly intellectual)

Intellectually Retarded Services (Health - intellectual disability)

Kate Cocks (Voluntary - multiple disability and total dependence)

Regency Park (Voluntary - predominantly physical disability)

South Australia (contd.)

Woodville Spastic Centre (Voluntary - physical disability but diverse disabilities represented)

Whyalla Early Childhood Resource Centre South Australia (Education - diverse disabilities, predominantly intellectual)

Kent Town Pre-school (Education - intellectually handicapped)

Townsend School for the Visually Impaired (Education - visually)

Western Australia

Child Study Centre, University of Western Australia (Tertiary - diverse disabilities)

Irrabeena (Health - predominantly intellectual)

Speech and Hearing Centre (Private - hearing impairment)

Pre-school Team - Elwyn Morey Centre (Education - diverse disabilities)

Hearing Assessment Centre (Education - hearing impairment)

Tasmania

Assessment Centre at Hobart (Health/Education - diverse disabilities)

"Elonera" (Health - intellectual disability)

Australian Capital Territory

Australian Capital Territory Schools Authority (Education - diverse disabilities)

- Bannister Garden (diverse predominant, with special concern for hearing impairment)
- Malkara (intellectual predominant)
- Turner (physical disability predominant)

Hartley Street Centre (Health/Education - diverse disabilities)

Therapy Centre (David Street, Throsby Crescent) (Health - diverse disabilities under 3 years)

A4

Northern Territory

Down's Syndrome Association (Voluntary - intellectual disability)
Spastic Centre (Voluntary - physical disability)
Stuart Park Primary (Education - hearing impairment)

APPENDIX B

QUESTIONNAIRE COMPLETED BY PROGRAM DIRECTORS

Contact person ______________________________
Title ______________________________
Postal address ______________________________

SIGNATURE OF PERSON COMPLETING QUESTIONNAIRE ....
POSITION ....

1. In what year did your program begin to offer services (even in an experimental or pilot stage)? 19....

2. What is the total number of children presently served by your program?
handicapped boys ...... handicapped girls ...... non-handicapped ......

3. How many children served by your early intervention program are in each of the following age groups?
    under 6 months ..... 3 yrs - 3 yrs 11 mths .....
    6 mths - 11 mths ..... 4 yrs - 4 yrs 11 mths .....
    1 yr - 1 yr 11 mths ..... 5 yrs - 5 yrs 11 mths .....
    2 yrs - 2 yrs 11 mths ..... 6 yrs and over .....

4. At the time when your program began to offer services, what primarily influenced the establishment of your service (e.g. formation of a group of concerned parents; a survey by a voluntary organization which already served school age children; visit by an expert who advocated early intervention)?

5. If your program has changed in any major direction since it was initially implemented, please describe the types of change which have occurred.

6. What is the major source of funding for your program? ____________________

7. What other sources of funding do you have? Please list sources. ________

8. Please describe the administrative structure of your organization.

9. How many children receive each of the following types of program as part of your service?

    A. Home-based program - a program implemented in the child's own home, whether by trained parents or professional home visitors, and possibly involving the child's visit to a centre no more than once per month. .....

    B. Centre-based program - a program requiring that children leave their house to come for the program, whether the centre is a permanent facility, a mobile unit, or someone's residence, and possibly involving home visits to the child no more than once per month. .....

    C. Integrated Home/Centre-based program - a program providing both Home-based and Centre-based services to the same children. .....

10. Please classify all the children served by your program according to their primary disability (e.g. you would classify a child with mild cerebral palsy and severe mental retardation as primarily mentally retarded).

If a child has more than one major disability, indicate this under the category "multiply handicapped". Use the multiply handicapped category for as few children as possible.

Primary disability	No. of children served
Mental retardation (including developmental delay)	.....
Physical disability	.....
Hearing impairment	.....
Visual impairment	.....
Other (please specify)	.....
Multiply handicapped (2 or more major disabilities e.g. deaf/blind)	.....

11. Do the parents of the children attending your program have a parents' organization, group or committee? Yes ..... No .....
If 'yes', please describe the purpose of the group __________________

12. Does your program regularly provide meetings or workshops for the parents? Yes ..... No .....
If 'yes', please specify the type(s) of meeting(s) or workshop(s) and specify how often they take place. ______________________________

13. If your program regularly communicates with parents, please put a tick in the box beside the forms of communication you use.
(a) General newsletter .....
(b) Written progress reports for each child .....
(c) Arranged meetings with parents at home or at centre ....
(d) Informal meeting with parents at home or at centre .....
(e) Telephone conversations .....
(f) Other (please specify) .....

14. If your program has a centre-based component, please describe the type and location of the building(s) used by your facility.

15. Please describe the outdoor play area available for your program.

16. How many paid employees are full-time members of the early intervention program staff? Men ..... Women .....

17. How many paid employees are part-time members of the early intervention program staff? Men ..... Women .....

18. Which of the following full or part-time paid staff provide professional services for the early intervention program? Please specify the number of people from each professional group involved and specify the average number of hours per person per week. (If the staff provides services to other age groups, please estimate the hours spent only on children in the early intervention program.)

	No. of people	Average no. of hours per person per week
(a) Occupational therapist(s)	.....	.....
(b) Speech therapist(s)	.....	.....
(c) Physiotherapist(s)	.....	.....
(d) Teacher(s)	.....	.....
(e) Social worker(s)	.....	.....
(f) Psychologist(s)	.....	.....
(g) Other(s) (Please specify)	.....	.....

19. Does your early intervention program use the help of volunteers?
Yes ..... No ..... If 'yes', please provide the following details.
(a) Total number of volunteers used in the program .....
(b) Average total number of hours of volunteer time used by the program per week .....
(c) Please describe the main tasks undertaken by the volunteers ....

20. If your program is centre-based, are there problems with transportation of children to the program? Yes ..... No .....
If 'yes', please describe any problems or difficulties. ______________
If 'no', who provides transport? ______________________________

21. What kind of publicity did your program have during 1979? Please specify the purpose of the publicity. ______________________________

22. Which methods of publicity do you find to be most effective? Please describe. ______________________________

23. Did any staff member of the early intervention program attend a conference or seminar outside your program during 1979?
Yes ..... No ..... If 'yes', please provide the following details.
(a) How many paid staff members attended conferences or seminars? .....
(b) Please describe briefly the subject of the conferences or seminars.

24. Please describe assessment methods used to monitor each child's progress.

25. Please list any commercially available program materials, checklists and/or tests.

26. Please enclose any readily available printed materials such as financial statements, program timetables, charts of administrative organizations, program descriptions etc. that will help us to know more about your program. Printed materials enclosed ..... Not enclosed .....

THE FOLLOWING SECTION IS DESIGNED TO ENABLE YOU TO OFFER YOUR OWN EVALUATION OF YOUR PROGRAM

27. Please state what you view to be the purpose of your early intervention service.

28. Please describe any methods you have used or are using to evaluate your program.

29. What financial problems or needs do you feel your program presently has?
Financial ____________________ Other ____________________________

30. What do you see as the main strengths of your program?

31. How do you see the future of your program in terms of the services to be offered by it and the factors that may affect the service offered?

32. In the space below, please add any additional comments you feel are appropriate.

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY.

Program ____________________

APPENDIX C

QUESTIONNAIRE FOR PARENTS OF YOUNG CHILDREN WITH DISABILITIES

(Sent to parents of children in some site-visited programs)

1. What is your relationship to the child?

Mother (tick one)
...Natural mother
...Adoptive mother
...Foster mother
...Stepmother
...Other ____________

Father (tick one)
...Natural father
...Adoptive father
...Foster father
...Stepfather
...Other ______________

2. How old is your child? ____

3. Is your child a boy or a girl? _____________________________________

4. How many children (including the child with a disability) are living with you in your home? ________________

5. How would you describe your child's primary disability? (Tick only one)
... Mental retardation
... Physical disability
... Visual disability
... Hearing disability
... Multiple handicaps
... Other (please specify) _____

6. Do you receive home visits as part of this program?
... Yes ... No. If 'Yes', how frequent are the home visits? (Choose the one answer that comes closest.)
... more than once a week
... weekly
... fortnightly
... monthly
... less than once a month

7. Does your child regularly visit a centre as part of this program?
... Yes ... No. If 'Yes', how many times per week does your child visit the centre?
... less than once a week
... once a week
... twice a week
... three times a week
... more than three times a week

8. What was the main way you found out about the program serving your child? (Tick only one)
... From a friend or relative
... From a therapist, doctor, teacher or other professional
... From publicity about the program
... In another way (Please specify) ________________________________

9. Why did you decide to have your child participate in the program? ____

10. How helpful do you feel the program is for your child?
... Extremely helpful
... Fairly helpful
... Slightly helpful
... Not helpful at all

11. Have you noticed any changes in your child's behaviour or activities at home since he or she entered the program?
... Yes, many changes.
... Yes, a few changes.
... No, no noticeable changes.
If 'Yes', please tell what kinds of changes have taken place. ________

12. Has the program helped you as a parent in any way? (More than one can be ticked.)
    - ... No
    - ... Yes, it has relieved some worries.
    - ... Yes, it has helped me learn how to help my child.
    - ... Yes, it has helped the family to understand and deal with the child.
    - ... Yes, it has enabled me to get acquainted with parents in similar situations.
    - ... Yes, it has helped me in other ways. (Please tell us what ways)

13. How long has the child been in the program? ______________________

14. Do you think the program serving your child might be expanded or improved to be more useful? ... Yes ... No.

15. Approximately how often do you have a chance to talk with the program staff about your child or family? (Choose the one answer that comes closest.)
    - ... more than once a week
    - ... weekly
    - ... fortnightly
    - ... monthly
    - ... less than once a month

16. Would you like to have more opportunities to see and talk with staff members of the Program?
    - ... Yes
    - ... No, I talk with staff often enough.
    - ... No, I would prefer talking less with staff.

17. In your opinion, who should have the major responsibility for providing services to very young children with disabilities? (Tick only one)
    - ... Federal government
    - ... State government
    - ... Local government
    - ... Voluntary or charitable groups
    - ... Others (Please specify) ______________________

18. When your child is ready to attend school, what kind of school do you think he or she will be able to attend?
    - ... Regular school
    - ... Special school or special classes attached to regular school
    - ... Other (Please specify) ______________________

19. From whom do you receive support, encouragement, and help in relation to your child? (Tick one answer for each group or individual listed.)

	A great deal	Some	A little	None
Example				
Husband or wife				
Friends				
Relatives				
Neighbours				
Other parents of children with disabilities				
Priest or clergyman				
Doctor				
Program staff				
Other professionals				
Other groups or agencies (Please specify)				

20. In the table below, can you provide information on other programs assisting the development of your child with a disability? (Omit if your child does not participate in other programs.)

Name and address of program	No. of times per week your child participates	Your overall assessment (Tick the appropriate space)			
		Extremely helpful	Fairly helpful	Slightly helpful	Not helpful
Name Street Suburb or town City State Postcode					
Name Street Suburb or town City State Postcode					
Name Street Suburb or town City State Postcode					

21. What help do you need or want that you are NOT receiving? ____________

22. What are your greatest worries about your child (with a disability)?__

23. How do you view the future for your child?

24. Who filled out this questionnaire?
    - ... Mother only
    - ... Father only
    - ... Mother and father together
    - ... Other (Please specify) ________________________________

25. If you think the program serving your child might be expanded or improved to be more useful, please describe the changes which you think could be made.

26. If you have concerns or feelings that we have not asked about, please write comments freely below.

Thank you for your help.

APPENDIX D

A SAMPLE OF COMMENTS FROM PARENTS

This sample represents about 10 per cent of the parent comments that were elicited by questionnaires.

Comments were selected to reflect as accurately as possible the flavour of parent concerns and the relative attention given to the various issues under which we have categorized the comments. The issue about which parents made the greatest number of comments was the responsiveness of services to the needs of families and their children with disabilities. Also important were lack of public awareness, the rationale of programs, logistical problems that prevent parents from availing themselves of services, funding uncertainties making parents insecure about future intervention, and the focus of programs.

Comments were also made about the relationship between intervention and other specialized services, communication between the program and other community services, staffing of programs, monitoring and evaluation, and responsibility for future provisions. Any specific references to names of people or programs have been deleted to preserve the confidentiality of parent comments.

A SAMPLE OF COMMENTS FROM PARENTS

Comments related to the rationale of programs

I feel that there should be more help available for the extended family to accept the Down syndrome child, as parents have to support family aggression, disbelief, etc., whilst trying to cope with own emotional feelings. If the extended family could be helped to give support to the parents and siblings of a Down syndrome child, the load would be much lighter.

The program my child attends would be improved by smaller groups of children or more teachers, resulting in more individual attention to each child.

Our main concern as parents is that the child will need lots of assistance with employment.

No program is going to change the condition of your child, i.e. bring back to normal. You can only shape the progress of your child in line with a normal child's growth patterns. The degree of success depends on how retarded the child is - what we mean is some have higher IQs than others, also on how hard you want to work with your child.

I feel that a speech therapist must become a more important part of the lesson and have regular contact with the child, and not used only to advise the teacher.

I feel that not enough attention is paid to occupational therapy, possibly because of shortage of staff, but surely the first years are very important. If not allowed to use their hands they will surely lose the inclination to use them, and we feel that 1 hour a fortnight until age 3 - 3½ is just not enough.

I am concerned about how other normal children will finally accept her. As we are all (doctors, therapist, and parents) still uncertain as to what her disability will finally be, it is still an unpredictable future.

It would be better if the children would be able to see their therapists more often than once a month. Or that they could attend (possibly if necessary with a parent) some kind of class where the therapists would see more of them.

I think there should be more programs available during the week. As our children aren't invalids I think they are capable of a lot more than they are given credit for. Also I think there should be more teachers trained to help our children throughout normal schools.

The most benefit I and others have gained has been from government agencies which provide support for the parent and treatment for the child. Why are those in private practice reluctant to channel suspect cases to these agencies?

Education as one service, not all separate, e.g. all specialists working together for the good of handicapped children, not programs run by different groups or agencies, but as one group.

Comments related to focus of programs

I feel the integration of "different" children into "normal" schools wherever possible is a big step towards educating others about handicaps and understanding that they have their rightful place amongst us, not "shut away".

Ever since our child was born we have constantly come up against a barrier with social workers and others who convey the feeling that our child, by the nature of her disability, is placed in a category the same as all others with a similar disability. Just as there are the dumb and the brilliant in normal people, surely this can be said for those with disability. But because of what she has, these people wish to 'write her off' with the rest. We do not want her to perform miracles, just to be allowed to perform, or should I say be given the chance to perform to the best of her ability, whatever that may be.

I have had a lot of difficulty trying to find a program that caters for multiple handicaps. I have help in teaching her things despite her blindness, but her physical disabilities, coupled with retardation, seem to inspire most people to think she only needs to be cared for and not stimulated.

I have always felt very strongly that children with disabilities should be included in ordinary schools and all schools should have access to special teachers and facilities to provide for their special needs, as already is done with remedial teachers and migrant teachers. What's so different about these groups?

During the middle of the year my child attended a normal pre-school and I find it hard to say which school has been the most helpful and to what extent. The staff at the normal pre-school are aware of my child's disability and have great patience with him.

I think some professionals lose sight of the fact that regardless of who provides the help needed, the paramount aim should be the achievement of each child's full potential.

In a case where the child is profoundly retarded, there is little or no help available; you just have to make do with programs set up for mildly or moderately handicapped children.

More physical and practical remedial treatment by specialist staff is needed.

Comments related to relationships between early intervention programs and the wider network of special service for handicapped children

If our daughter were left an orphan we would like reassurance that she would continue to receive loving care as an individual and not "another case" and that she be treated with patience and love as at home and not by unsympathetic staff for whom it was "just a job".

As far as I am concerned there is not a better place for a handicapped child than his own home, as long as his parents can accept and cope with his special needs. Day care for school-age totally dependent children is virtually non-existent.

Special extra schooling should be supplied outside school hours at government expense in areas that may not be up to standard in the child's development, or in helping to adjust to other society standards.

I would like the centre to provide more home visits and it would be nice to talk to a social worker in my home. I have seen a social worker once in my home and once in the centre. I feel they could do more.

Another concern is the lack of communication between the various agencies which provide services; also the uneven distribution of funding, so some children are very well catered for, while those who do not fit the criteria of existing services miss out completely or receive very limited assistance.

We feel that after schooling is completed, there is a definite need for a type of employment program (within established industries if possible) that provides a challenge for these people, rather than the soul destroying tasks currently available (weighing nails, peg-making etc.). We see our child and others in current early intervention programs doing work better suited to their future capabilities like all human beings; these people need to feel that they are capable of performing the next (more complex) task, thereby creating a sense of achievement and a desire to progress.

Comments related to communication between early intervention program personnel and relevant services for the community at large

I'm concerned about lack of communication between departments dealing with care (i.e. physio, occupational therapy, psychologists). Also the distance travelled to the .... Centre makes communication and liaison difficult.

I only wish that the various centres could work together more instead of being isolated from each other - that there was more communication between the so-called professionals.

I think organizations like .... and .... should be notified of a birth where the child is retarded or has some disability. It is very important in the first few years for a disabled child to receive all the help he can. Doctors, child nurses etc. should have a responsibility to every child to check for retardedness, and let the parents be aware of the problem. I was left wondering, for 2½ years, what was wrong with my child before receiving any help. We must avoid situations like that.

It seems such a waste not to be able to pass the information and expertise gained by the ...... program to all the rest of the community (with handicapped children) more quickly and directly. There should be more rapid flow-on to the various play-groups, pre-schools, parents' groups, so that they can also benefit from the enormous success of the program.

More communication between therapists and doctors. Comprehensive reports by speech and occupational therapists and the pre-school teacher co-ordinating the play-group were prepared last November for a panel for educational placement. However, at her 3 YO check in November, 1979, the therapy centre doctor was unaware our child had been having occupational therapy (at the centre) since July, and in February, 1980 our referring paediatrician had no reports at all from the centre on our child's progress.

Comments related to sources and adequacy of funding

Places for permanent residence of young adults upwards are needed to enable them to live an uninterrupted normal life, and this should be financed by the federal government. Totally dependent children also need good, clean, well run residences and not what is on offer at present. They are not good enough! Federal money should be readily available for facilities for children and adults with disabilities, perhaps at the cost of overseas aid. They need help now.

I feel the state government should be responsible for the provision of services, but unfortunately the services existing in this state already do not offer the assistance and concern for handicapped children under the age of 2 years, unlike the services provided by voluntary and charity groups. This is the time that is probably the most important for both parents and children to become acquainted with and learn to accept their disabilities.

A18

We are concerned about the funding of the programs which help our child and the rumours that the help may be cut back. Our children need this help so desperately and also we as parents need support and advice from people whom we feel are competent, on a regular basis.

Handicapped people, friends and relatives, should not have to beg for assistance by way of charitable organizations. The parents and family have enough to do to cope with the running of a non-normal home due to the handicapped child, let alone running about helping and organizing charity do's. Also, calipers, etc., should be a medical benefit.

Although the Handicapped Child's Allowance of $15 per week is available, this in no way covers the cost of keeping a severely handicapped child at home. It is essential to run a second car (large enough to accommodate a wheelchair), special clothing, baby-sitting of other children when handicapped one is hospitalized etc. There should be a system whereby the parents of multi-disabled children receive more allowance than, say, a child who has lo[illegible]ouple of fingers.

I would like to see all services for all handicapped children united in one education system so that they may be able to put more pressure on governments for support for our children. It appears to me that some handicaps are "elitist" and have many services, where the less accepted handicaps miss out.

I feel that the government is not doing as much as it should and I am sure it can. Our children, even with their disabilities, are human beings and citizens of the country. I have seen with sorrow, more than with surprise, how in this so-called International Year of the Child, the government has spent a lot of taxpayers' money in posters, nice songs and all forms of publicity, preaching about the importance of such an event; but the practices and the learning for the kiddies are as poor as they could be. Just to celebrate this year the government has cut the most vital things for a kid: Health and Education; and just to have an idea of the care for kids campaign of the government, let me tell you that the ....'s always poor financial support from the government has been cut even further. The occupational therapist had to be dropped when the number of kids needing help is increasing day after day. Another example is.........., a wonderful place which provides toys for the kids and support for the parents. They can't buy many more toys and equipment this Year of the Child. What about after?

I feel there should be more government help to establish more similar programs and to keep them going without so much need for fund-raising and would wish for help for all handicapped people to be able, if capable, with aid from social workers perhaps, to be able to live as adults independently and not be put away in institutions.

Too much emphasis is placed on bricks and mortar - not enough responsibility accepted by government agencies for ongoing staff funding. Not enough feedback from research to the client (child or parent).

Comments related to responsiveness to the needs of families with young handicapped children

Because we live 146 km from (capital city) I cannot get to the .... Centre as often as people living in the city. Also, I have 3 other children to consider. In the past I have been staying at the .... Centre for a week at a time, about every 3 months. It also depends on when the flat for country parents is available. Often it is booked out months ahead.

Handicap allowance wasn't brought to our notice until 3 months ago - we should have been informed at birth. In our case our boy had a severe physical disability dealt with by an orthopaedic surgeon who had no interest in effects and development or the psychological effects of treatment (involving much surgery, plasters, splints from birth). Thus the person as a whole was dealt with inadequately until this recent program - far too late!

Parents should be given an opportunity to talk to other parents with a handicapped child soon after being told about their own child.

Often children with multiple handicaps are shunted from one organization to another because they don't "fit" into any one scheme. This involves a great deal of travelling. Very little information is given to parents about organizations when the child is very young, probably because doctors don't want to commit themselves to any drastic diagnosis, but a lot of important early learning time can be wasted. Why can't they refer parents for help, even if things are not as grim as first thought, there's no harm done, but the longer they wait the harder it is to teach the child, and facing the fact that your child is handicapped is no easier for being left.

My pleas are (a) that specialists be encouraged to view total child and know something of early child development in more than "physical" areas, (b) that parent worries be analyzed to see what is being complained of - rather than considering resources available first and putting child in, in "hope" that it may benefit child; e.g. within two visits to toy library (to which I referred myself in desperation), I had been given practical help in language programs for my daughter as well as stimulating material for her "stage" of development.

I have been upset at the pressure that is applied by doctors and some people concerned with this program to have my child placed in an institution or nursing home.

I have a very poor opinion of doctors as a result of ......'s disability. With the exception of one (who is not a local doctor) they do not understand what is wrong with ...., and have no idea what to do about her. I am very bitter about the way we have been treated by doctors.

If we are not always available to guide and care for our child, we can't see any of the present institutions or sheltered workshops being suitable. It seems there are no "half-way" measures. There is either the care at home or the INSTITUTION.

A20

Very little community help is available to help parents caring for disabled children in their own homes. Domiciliary care does very little assisting in this area, only ramps etc. for housing because parents are "able bodied". How long is this so, both from a physical and mental point of view?

We have always had a great rapport with the professionals who work directly with our daughter - but often clash with "those who rule" at the top. It often seems that compassion is lost in the climb to the top. Also at the very beginning to be told bluntly that your child is Cerebral Palsied, no prior preparation or knowledge of the problem and no further explanation - just being told to attend a clinic which contained about 300 people all talking in medical terms way above our heads. It is no wonder many parents give up on their child before things can get started. Looking back now I feel that was the greatest test of my life, and if one survives those first weeks then the rest is down hill. But I sympathize with all those parents who have to be put through this high-class razzle dazzle. They need plain explanations and simple assurances that help will be available to them and made to feel how important their part will be in what treatments are to follow.

The "professional" attitude of seeing everything as a 'problem' which has to be dealt with is a real bugbear for us - hence the low-key contact. (Seeing the child as a handicap with a child attached, rather than vice versa.) The toy library people are the reverse - life is for the living, the parent support is there and the "how did you survive that period?" (pat on the back - never goes amiss) attitude is there too - i.e. relaxed and casual.

I am concerned at the lack of communication between medical people and program staff and there is an apparent reluctance of the medical profession to recognize the worth and value of such a program at the earliest possible age, for both the child and the family. I also feel that the public should be educated to realize the needs of handicapped people and understand and accept their differences and not hide them behind the walls of institutions.

Would like mother to be considered more, with frequent breaks from child, as it is a great mental and physical strain coping with a mentally handicapped child seven days a week, and a family as well.

The medical profession in general does not give much encouragement to parents of handicapped children, i.e. mentally retarded children. Social workers were a complete waste of time; whilst the visiting nursing sister was encouraging, very helpful and full of practical advice, as is the local Baby Health Centre.

I seem to have difficulty finding out about the learning difficulties my daughter may encounter. Nobody seems to want to assume too much, either because they don't know or are unwilling to say. I am open to ideas on any help and we participate in any new schemes, and I seem to be getting more knowledge of her problem through reading books recommended by a child psychologist.

I don't speak English well and it's very hard to understand and to ask them about my problems.

Our child suffers also from epilepsy and we feel if we could use some type of day-to-day care centre for her, we may, as parents, be able to cope more readily with her problems.

We have found that by far the greatest pressure created by our circumstances is this: so much time is spent with ...... and his programs that other responsibilities become neglected, especially the other children and the house work. This causes parents to be somewhat depressed from time to time. The greatest burden falls on the mother, and consequently she is always tired due to the long hours required to cope, and is always under stress due to the backlog of housework.

Need for more help at home and more contact with professionals who understand and know, and with whom I can talk and get to understand, and help my child more at home and to get my family also to understand the need and to get them involved. Also transport. As I can't drive, I have to depend on public transport which is very unreliable where I live, and I depend on other people to take me to places I need to go. Sometimes I get so upset about this transport business that I feel like giving up and just staying at home and resuming a normal life again.

It worries me a great deal that specialists and G.Ps do not appear to be aware of the help which is available to a worried parent. The most benefit I and others have gained has been from government agencies which provide support for the parent and treatment for the child. Why are those in private practice reluctant to channel suspect cases to these agencies? Three specialists treated my child and not one offered constructive help - only platitudes.

Comments related to the roles of family members in programs

There should be more push by therapists, etc., for home (parent run) programs which reinforce ones run at the institutions. We could become complacent and leave the education, therapy, etc. to them.

Not enough emphasis is placed on the value of experience of parenthood with other children before having to cope with a handicapped child, and the assistance we have from older children in the family.

I think it would be helpful for other similar organizations to involve the entire family. I feel it helps the family overcome any anxieties and helps to accept the situation much quicker.

More government assistance to provide more program staff for a good one-to-one program. Although the staff cope remarkably well, more sessions for parents (on group counselling basis) to talk over problems.

I feel the therapy centre in ..... hasn't much knowledge of how to cope with children with physical deformities and more or less "play it by ear" as to what advice they give you. There is no therapist available who has been trained to specialize in this treatment and I'm told nothing is available in literature as a guide. My child's case may be isolated, however, but I feel some training should be given to teach the parents of the children how to best deal with learning to adjust to an artificial leg and what physiotherapy should be exercised.

Parents should be told more about the program. Maybe once a fortnight after picking up their child from the pre-school, the parents could be lectured by the teacher about the program, what activities their children have been doing, the aims of the program, what weakness each child has or any problems the teacher might be having, or any development a teacher may have noted in a child. Maybe each parent could be given certain activities to do with their child for the next fortnight. To compensate for the extra work for the teacher, the children could probably attend the centre less.

I would like to see a scheme similar to the Portage scheme in the U.S. initiated, in country areas in particular. That would entail the parents being utilized as therapists and trained to help their child by professionals.

Comments related to the staffing of programs

Lack of facilities in the country, thus making it necessary for the child to leave home at an early age and become a resident in an institution in a city many miles away. Also at present the visiting teachers are not based in country areas and therefore cannot provide the full back-up service that is required when a child returns to a regular school.

I am concerned that there are not enough 'remedial' assistants (in view of the supposed 'over-staffing') in state schools and feel that there should be more done in this area; not only for children with Down syndrome, but other physical/mental handicaps as well.

The program is tremendous, I will be most distressed to see it stopped or not even implemented with more staff and time, particularly in the area of speech and psychology.

We feel that some of the staff are not suited for the work they are employed to do as they don't have enough patience with some of these kids. My wife was told by one member of the staff that our child was a burden on them and that she took up most of their time. We don't want to report this matter to the principal for fear of repercussion to our child.

The inclusion of a speech therapist as part of the teaching staff. Stricter supervision of the program to ensure all pupils are receiving constant, individual tuition. Conference between teacher and parent at end of each term to inform parents how the child is progressing, what the parent needs to work on most at home, etc.

I feel there should be more qualified people available to assist in a program which covers a wide area. Perhaps there are not sufficient courses for would-be trainees to enrol in? If the shortage of staff could be overcome, particularly in the physiotherapy and speech therapy field, the program surely must expand (to be more useful).

The ..... are so short-staffed. We have one physio of a Monday for an hour and a half. She has to attend to 10 children. Five minutes with each. One Occupational Therapist who is hardly ever there, and no Speech Therapists... left 3 months ago.

I have criticism to make of the Education Department. It is not possible to make a therapist into a special Ed. teacher - and to place her in charge of the unit is to the detriment of the children. I do not make any criticism of such therapist working in her own field. I feel at the moment that I will always be my child's teacher; despite my inexperience and lack of knowledge I feel that the special schools will mainly concentrate on social skills (which are important) but won't do much to help her reach her limited potential in the academic area.

Also I think your staff need more help to be able to give more individual attention. I know "thank you's" are not very much but I would like to say it anyway. You have and are doing a wonderful job for our very special children, as I'm sure all mothers have told you in many ways. I just hope in the future that a bit more is done, as they are the most wonderful and important part of our world. I just wish others would think the same as we parents and you people who work to find places for our children in society.

Comments relating to the monitoring and evaluation of programs

The program itself is excellent, but I think the over-enthusiastic staff put far too much pressure on the parents without realizing same. My husband and I have just this month returned from a visit to the U.S.A. In several cities we were able to visit similar programs to the one our son is doing. We were delighted to find all of the programs so similar and in Washington State we both assessed a program that was the most advanced we had seen (this is the same program that our son is following). Our regret is that there is only one program of this kind in Australia. If we can be of any further help we would be happy to do so.

[illegible]

I wish there was more publication for the general public about the problems parents have with their cerebral palsy children, e.g. handling the child, feeding problems, behaviour problems.

There is a subtle sense in which [illegible] is implied parents are responsible [illegible] developmental learning problems makes it even harder for parents.

My child is a warm, loving, cute and sometimes naughty little girl. She is a delight to myself, her father and our family, but so many times I have come up against rude, thoughtless people who consider she should be in a home. Even my husband's parents have avoided her since they were told of her problems. I have been stunned by an adult who wouldn't let her near her own child in case she "caught it". How incredibly ill-informed we are as a society. I honestly believe if we used the medias available to us in a more educational way, not just to ask for money, children like mine would be able to look forward to a more acceptable future ..... I think a television program showing the differences of how people handicapped from birth and handicapped by accident can still end up in the same condition, should be made available to T.V. stations and high schools.

We welcome the trend to integrate handicapped people into the community as much as possible. However, we feel that a great deal could be accomplished by further educating the community to the needs of the handicapped, both children and adults, e.g., T.V. programs showing how teachers work with blind and deaf children to accomplish certain objectives is a simple example. Unless one has had contact with the handicapped, one's immediate reaction is usually limited to pity, and maybe limited encouragement.

If we had realized there were programs like the one our child is now participating in we could have hoped to [illegible] a lot earlier. The improvement [illegible] shows how much can be done with children [illegible]

There seems to be too much duplication of services - the medical services in particular. In a matter as simple as deciding whether a child would attend the normal school or a special school, there is a bewildering array of opinions. There is no single channel through which we can take/obtain right advice as to what to do, how to do and when to do it.

The attitu'. of hospital staff (when the child is born) is well wishing, but utterly useless. There are not enough social workers! There is also a total lack of information in the hospital for the parents of the newborn child, who crave the information of what exactly their child is all about and what help is available, such as special programs, etc.

hospital, but I should not have waited a year or so. You have to get out and talk to people who know what to do. For example parents need to be told, while in hospital, of money for the handicapped. Many mothers have missed out 6 to 10 months. I have to turn off from my brother and sister-in-law and a few friends. People who tell you to drown her are stupid and telling me I will become bitter if she continues the way she is. You see she has a chance - she is doing very well, always smiling. Their school teachers don't understand.

Many doctors are unaware or uninformed about the facilities available for handicapped children. Programs need to be given more public airing, not just among the parents of handicapped children, but also doctors and the general public.

By the age of three years, much of the adjustment on the part of parents has been done. What was much needed, but not provided, was some counselling early on, even after the child's birth. Not crisis counselling when things are so bad that people feel they can't go on, but preventive counselling to make parents aware that they are not alone, that their feelings of frustration, distrust of professions, anger, etc. are quite normal. More help in the early years as to how to handle the child at home, and where to go to get information on child's condition, services, etc.

To rely on public libraries for out-dated information is not too good. More public awareness is necessary, I think, in certain conditions. There can be confusion with different types of handicap.

I feel confused about programs, and the course my child should take in his future education. I would like to see an independent body with a full and continuing knowledge of programs, set up solely to assess the children and advise parents where to place their child.

Comments related to responsibility for the future provision of early intervention services

We live 165 miles from ..... and therefore are unable to obtain full benefit from the program available. As our child progresses, our needs for the program will be much greater, so we would like to see more specialized schools in country areas.

Help given early enough leads to a lot less heartbreak later on for parent and child. It should be compulsory at 12 and 14 months for all children to be assessed and help and advice given if so needed by people specialized to carry out this task. We would like to see this come to reality in 1981 - in the International Year of the Handicapped Child.

It's just a shame that the aid given here in ,,(capital city), is not available in every state.

[illegible] timetables, distance, etc.)

It is depressing, when one co-operates as fully as one can, even to the extent of travelling 1½ hours a week to attend weekly sessions of one hour (plus all other attendances for follow-up of other medical factors) only to find that the people involved increasingly find it hard to cope with your daughter, and when they reach the point of no progress suggest another [illegible] organization for you to 'check out'.

I feel more should be done for country families with disabled children. It seems at the present time that if you have a child who needs regular therapy you're expected to sell up and move to the city, as the large cities are the main places for your child to receive the best treatment. With the jobs hard to get and likely to get harder, people cannot be expected to give up their security, and yet at the same time you're left feeling guilty that maybe you should be doing more for your child. Surely as more state governments move towards decentralization of cities and industries, the need for centres for the disabled in country areas must grow.

The country people in ....(State) only have home visits from the program staff about once every three months, and many of the parents of "problem" children feel that country people need more help and visits from program staff. City parents of "problem" children have easy access to centres and therefore should not need home visits. We would like to see country visits increased to once a month.

Because of distance and the fact that my child is greatly stressed by travelling, she very rarely attends any programs. From 2 weeks of age until 3 years she attended twice weekly to a variety of physio programs, with no progress and no benefits; rather it created problems for myself travelling.

Should be full days, not half days, and transport should be provided automatically for children over 4 years of age.

The distance which we travel to get help - the minimum we travel is 40 miles, maximum 70 miles [illegible] However, it helps him enormously.

I feel that the government should assist further, by way of financial assistance, in view of travelling costs to centres; and make a review of any financial hardship which may be placed upon parents, as many items are not covered under health schemes.

We live at ....20 km from the city, and during 1979 twice weekly we had to drive him into pre-school, wait several hours and bring him back. We found this a great time and money burden. We consider ourselves fairly fortunate money wise; some families could find it impossible to finance a twice-weekly trip. Assistance from a government body towards time off from work for travel, or a pick-up and delivery service is suggested. Please do not think this is a request from us for financial assistance.

It would be rather difficult to improve for us, as we live so far away and do not take ..... (boy's name) to ..... or ..... regularly. Nor do we have time to write many letters about him. A [illegible] various therapists for isolated places like ours would be helpful - this is an aboriginal community [illegible] fairly frequent to be [illegible] and other parents, as well as just seeing the children.

Definitely needs expanding as we only receive advice approximately twice monthly, from one advisor with staff so limited it's impossible for country visits to homes. Education of medical profession re help available to parents - most parents have to look for help; this should not be the case.

BRIEF REPORT ON WORKSHOPS

The Workshops held in conjunction with the study took place in the capital cities of all states and territories of Australia between June and August 1980.

The primary purposes of the workshops were:

(a) to communicate the interpretation of preliminary findings of a national study of early intervention;

(b) to elicit reactions (confirmation, criticism or explanation) to the findings and articulation of the issues;

(c) to facilitate interaction among parents of children involved in early intervention programs;

(d) to encourage communication about early intervention issues among agencies and departments serving the handicapped.

Invitations were sent to program staff, to parents via program staff, and to government department representatives.

Each workshop occupied two days. The program for the first day was for program staff.

Initial findings of the study of early intervention programs were reported, and participants offered their reactions. A panel presented discussions of major issues related to early intervention, in response to a list of issues emerging from the study that was provided by the Schonell Educational Research Centre to panel participants. The panel members included directors of programs, staff providing direct service to children, and government department representatives playing a major role in areas closely related to early intervention. The afternoon was devoted to discussion groups pursuing issues raised in the previous sessions.

Among the handouts at the program workshops was a list of early intervention programs identified in the state, with appended pages permitting attendees to suggest other possible programs, and a review of some materials used in site-visited programs.

On the evening of the first day a public meeting was held, the purpose of which was to review the topic of early intervention and to present selected findings of the national study of early intervention. Audiences at these meetings included parents who were unable to attend daytime workshops; representatives of intervention programs, departments, and agencies serving the handicapped (including those unable to attend daytime workshops); interested members of the public; students; and tertiary education staff.

The second day of each workshop was for parents of children participating in early intervention programs. As on the first day, a report of findings of the study of early intervention programs was presented. Small groups discussed issues raised by the study; in particular, parent response to questionnaires distributed to a sample of parents. Handouts at the parent workshops included a reading list for parents of young children with disabilities and a list of terms likely to be found in books dealing with handicapping conditions in young children.

A book display was provided for each of the workshops. The Helios Art and Book Company was responsible for a South Australian display and the Dominie School Centre for the other states and territories. In most states a radio talkback or interview with one of the Schonell Educational Research Centre Staff was used to heighten public awareness of the issue of early intervention.

Valuation forms requesting information on the efficacy of the workshops were sent to participants in the program workshops in most states. One hundred and fifty-six forms were returned to the Schonell Educational Research Centre. The evaluation forms sought feed-back on the usefulness of the workshops, ways in which they might have been improved and their overall effect. The number and percentage of responses to each question are given on a copy of the questionnaire on the following two pages. Please note that percentages are separately computed for each possible answer since not all respondents answered all parts of each question.

Total Number of Evaluation Forms Received	
N.S.W.	31
VIC.	25
TAS.	9
W.A.	10
S.A.	21
A.C.T.	3
QLD.	13
Not identified by state	44
	156

Evaluation Form - Total Figures and Percentages

1. Please rate the usefulness of the following opportunities provided by the workshops.

	Extremely useful	Useful	Somewhat useful	Of little or no use	Total
(a) To exchange ideas with the staff of other programs and representatives of departments and agencies	40 *25%*	72 *46%*	36 *23%*	9 *6%*	157 *100%*
(b) To learn about the study being conducted by the Schonell Educational Research Centre for the Office of Child Care	49 *31%*	79 *50%*	26 *16%*	4 *3%*	158 *100%*
(c) To provide information to assist the research team in understanding early intervention in the State	38 *24%*	65 *42%*	40 *26%*	13 *8%*	156 *100%*
(d) Other____________________ ________________________					

2. Please rate the following for their usefulness as ways we might have improved the workshop day.

	Extremely useful	Useful	Somewhat useful	Of little or no use	Total
(a) More discussion of issues with the research staff in small groups	64 *41%*	62 *39%*	27 *17%*	4 *3%*	157 *100%*
(b) More opportunities to exchange information with other representatives of programs and departments or agencies	59 *38%*	63 *41%*	30 *20%*	2 *1%*	154 *100%*
(c) More information on the findings of the study to date	45 *29%*	61 *40%*	33 *21%*	15 *10%*	154 *100%*
(d) More opportunities to raise questions of the research team about the study	44 *29%*	58 *38%*	45 *29%*	6 *4%*	153 *100%*
(e) More time for panel presentation of issues from the local perspective	40 *26%*	53 *35%*	51 *33%*	9 *6%*	153 *100%*
(f) Other____________________					

3. If the workshop has had any catalytic effect, please judge the likelihood of the following possible changes in your area.

	Very likely	Likely	Possible	Unlikely	Total
(a) More communication between staff members of various programs	19 *13%*	47 *32%*	61 *41%*	21 *14%*	148 *100%*
(b) Planning of state or local workshops enabling representatives of programs and departments or agencies to share ideas	8 *5%*	20 *14%*	73 *49%*	47 *32%*	148 *100%*
(c) Increasing government interest in early intervention	11 *8%*	25 *17%*	64 *45%*	42 *30%*	142 *100%*
(d) More attention by the staff of programs to examining what is being offered	27 *18.5%*	65 *44.5%*	48 *33%*	6 *4%*	146 *100%*
(e) Other ____________________					

We invite you to assess the workshop freely by writing any additional comments below and on the reverse side of this page.

Some comments were made, but they do not lend themselves easily to condensation. They were very interesting and helpful, often providing information on the local scene from an individual's perspective.

Thank you for your help

Optional

Name
Position
Organization
Street
Town/Suburb
City (if relevant)
Postcode

APPENDIX F

REVIEWS OF PROGRAM MATERIALS USED IN SITE-VISITED EARLY INTERVENTION PROGRAMS - 1979

Site visits to early intervention programs in various states revealed many materials used as valuable resources by intervention staff. A list of those materials appears below, categorized according to appropriateness for parents and/or program staff, and alphabetized by surname of the author. Following the list is a review of each manual, book, or set of materials.

The unpublished reviews have been written by Patricia M. O'Brien, presently of Burwood State College in Melbourne, Victoria. As an Educational Research Development Committee Training Fellow, she assisted the research team at the Schonell Educational Research Centre between January and June, 1980. Three reviews have been excerpted from *The Exceptional Child*, with the permission of the editor, Dr. John Elkins. The three remaining reviews were previously published in *Special*, the official journal of the Association of Special Teachers of Victoria. Anne Hoey, Review Editor of *Special* and author of two of the three reviews, has given permission for their use.

The purpose of the reviews is to provide each program with the opportunity to become familiar with material considered valuable by other programs. Programs not visited by the research team responded to a questionnaire which included a list of resources used in other early intervention programs throughout Australia. Following the reviews is a list of resources which at least three early intervention programs list as useful in their programs.

FOR PARENTS

Cunningham, C. and Sloper, P. *Helping Your Handicapped Baby.*

Jeffree, D. and McConkey, R. *Let Me Speak.*

Johnson, V.M. and Werner, R.A. *A Step by Step Learning Guide for Retarded Infants and Children.*

Pushaw, D. *Teach Your Child to Talk : A Parent Guide.*

FOR PARENTS AND PROGRAM STAFF WORKING TOGETHER

Hanson, M.J. *Teaching Your Down's Syndrome Infant : A Guide for Parents.*

Bluma, S., Shearer, M., Trotman, T. and Hilliard, S. *Portage Guide to Early Education.*

FOR PROGRAM STAFF

Chapel Hill Training Outreach Project.

Cunningham, C. and Jeffree, D. *Working with Parents.*

(For Program Staff - contd.)

Division for the Intellectually Handicapped, Perth. *Irrabeena Early Intervention Service Materials.*

Engelmann, S. and Bruner, E. *Distar Reading I Program.*

Fredericks, H. *et al.* *The Teaching Research Curriculum for Moderately and Severely Handicapped.*

Gentry, D. and Adams, G. *A Curriculum Based, Direct Intervention Approach to the Education of Handicapped Infants.* In N.G. Haring and D.D. Bricker (Eds.). *Teaching and the Severely Handicapped.*

Kent, L. *Language Acquisition Program for the Severely Retarded.*

Macquarie University. *Down's Syndrome Program Assessment and Curriculum Materials.*

Schafer, D. and Moersch, M. (Eds.). *Developmental Programming for Infants and Young Children.*

Uźgiris, I. and Hunt, J. *Assessment in Infancy.*

REVIEWS OF MATERIALS FOR PARENTS

Cunningham, C. and Sloper, P. *Helping Your Handicapped Baby.* London: Souvenir Press. Educational and Academic Ltd., 1976.

This book is written for parents of handicapped babies from 0-2 years.

Section One, "You and Your Handicapped Child", outlines the causes and characteristics of mental retardation and describes the anxieties encountered by parents when informed that their newborn child is handicapped.

Section Two, "Child Development, Stimulation and Teaching", presents a developmental checklist and profile against which the parent plots his/her child's program. The checklist is divided into the four areas of: Physical/Motor Development; Mental Development; Communication; and Personal and Social skills. Each area is further subdivided, e.g. Personal and Social Skills include: feeding, social, communication and emotional behaviours; anticipation and expectation; play and dressing, toileting and washing. The checklist items are explicit and the behaviours easily observable. A number coding system condenses the items into a developmental profile which can be used to record the child's progress every six to eight weeks.

The teaching strategies introduced include: modelling; shaping; prompting; cueing; use of consequences; task analysis and forward and backward chaining. Three techniques are suggested for use within a model of teaching that is comprised of the four stages, acquisition, proficiency, maintenance and generalization.

Section Three, "Practical Guidelines", gives parents suggestions for achieving the behaviours outlined in the developmental checklist.

Section Four, "Miscellaneous", concentrates on two areas. Firstly, behaviour problems and change strategies are briefly outlined and, secondly, a most valuable description of the ages of development across some of the checklist items for a sample of Down syndrome babies is given.

An inherent danger in encouraging parents to assess their own child's development is the anxiety it can provoke when the extent of the delay, as compared with normal chronological development, is identified. In this sense, the inclusion of the chart on Down syndrome development is of concern, particularly if the child assessed is further delayed than the latest ages given for the development of a particular skill.

Cunningham and Sloper further exacerbate the above problem by listing the practical guidelines for skill development in a chronological age sequence. A staged sequence of activities without age reference would be more appropriate.

The expectation of parents becoming educators, following the reading of one text without consultation and demonstration of educational techniques, is unrealistic. However, *Helping Your Handicapped Baby* could be a valuable resource guide for parents if used within the context of parent training, in either centre or home based programs.

Patricia M. O'Brien,
Lecturer,
Burwood State College,
Melbourne, Victoria.

Jeffree, D. and McConkey, R. *Let Me Speak.* London : Souvenir Press. Educational & Academic Ltd., 1976.

The authors are more than justified in stating in their preface that "this book is written primarily for parents whose children are slow in acquiring language but it should prove useful to anyone, parent or professional, who is interested in furthering any child's language development". It is"designed to give parents expertise without being too academic".

Following a general introduction, and a clear explanation of the format of the book in Part 2, Part 3 contains charts covering nine aspects of language development: spoken language; using language; understanding language; following commands; imitation of sounds; imitative play; make-believe play; objects; and gestures. These charts are arranged so that parents are able to see the stages of language development in each of the nine areas. They are instructed how to determine what level of language development their child has reached and which sections of the book would be most relevant to them. As helping a child acquire language is often a very slow process, the authors have directed parents to use these charts to record the child's progress so that they may appreciate the gains, no matter how small, that their child makes.

Part 4 is a very important section in that the authors mention many of the mistakes that parents make in attempting to help their child develop language. They make valuable suggestions about how to avoid these pitfalls and how to make the games in the following four sections more enjoyable.

In Section 1, parents are told how to initiate vocalizations and encourage babbling, and of the importance of sucking, chewing, and blowing in the development of speech. Speech sounds are given characters to encourage the child to have fun with speech. Suggestions are given to help the child establish the variety of speech rhythms; encourage good listening skills; understand the world around him; and develop his imaginative ability. The authors point out to parents the importance of frequently using a consistent non-verbal means of communication as a supplement to verbal communication to avoid frustration in those handicapped children whose speech is inadequate.

Section 2 deals with the important language skills of learning nouns, verbs and prepositions and the development of two-word combinations and the formation of sentences.

The authors present games and activities designed to help the child communicate with others in Section 3. Not only do they emphasize the importance of expecting speech from the child but, more importantly, they tell parents how to judge how much to expect. They simply explain basic behaviour modification techniques to shape the child's responses as well as the importance of meaningful and expansive questions in eliciting language.

Section 4 deals with language as an aid to thinking. It includes activities to help the child to use language in remembering: to learn to group objects and develop concepts; and, of the greatest importance, to develop an inner language.

With regard to games and activities, emphasis is placed on the parents utilizing their own skills and imagination. The involvement of the whole family in the activities is stressed. The games that are suggested are clearly explained and often accompanied by simple illustrations and diagrams. However, the authors do list commercially available materials for parents who do not wish to make their own.

This book comprehensively covers all aspects of the development of speech and language up to the level at which the child uses language in thinking. I would recommend this book to any professional person involved in the development of speech and language both as a book to recommend to parents and as a source of ideas. As the authors note "there are not nearly enough language experts to go around" and so, for many, the task of helping a child develop language rests solely on the parents. I feel this book is the guide that they so desperately need.

Carmel Smith,
Speech Pathologist,
Guidance & Special Education,
Queensland Department of Education.

Excerpted from *The Exceptional Child*, Vol. 24, No. 1 (March 1977), pp. 52-53.

Johnson, V.M. and Werner, R.A. *A Step by Step Learning Guide for Retarded Infants and Children*. New York: Syracuse University Press, 1975.

The learning guide was developed over a three year period at the Sunshine Centre for the Handicapped, Inc., Knoxville, Tennessee. The guide presents target skills across the areas of: sensory stimulation; social behaviour; imitation; gross motor skills; self care; language; fine motor skills and perception. 240 learning tasks are outlined. For each task an objective is given, a teaching procedure is described and necessary materials are listed. Inclusion of a checklist enables the parent or teacher to determine which task items the child can perform prior to the commencement of teaching.

Introductory chapters to the learning guide include an example of a daily schedule, procedures for recording daily progress, and teaching strategies necessary for implementation of the curriculum. The basic principles of shaping, reinforcement, punishment and prompts are covered.

Each subject area is introduced with a description and rationale. A brief summary of the major focus of each area follows:

Sensory stimulation (18 tasks). The tasks are aimed to compensate for the passivity of the retarded baby and provide stimulation in the areas of touch, sight, hearing and movement.

Social behaviour (10 tasks). Activities are aimed to encourage children to participate in both one-to-one interaction and group play.

Imitation (6 tasks). Attention to a model is taught, followed by imitation of simple nonverbal behaviour and verbal cues.

Sensory Motor (24 tasks). Activities listed are directed at helping the child learn to roll, pull, creep, stand, gain head and neck control, develop ball skills and acquire general muscular strength and co-ordination.

Fine Motor (17 tasks). Activities suggested assist in the development of grasping, manipulation, two-hand and eye-hand co-ordination, manual strength and dexterity.

Language (39 tasks). This section suggests activities which help to develop both receptive and expressive speech.

Perception (27 tasks). The activities presented are related to the development of concepts and visual and auditory discrimination.

Self Care (27 tasks). Activities to encourage the self help skills of eating, dressing, toilet training, and grooming are listed.

Discussion

The learning guide is compactly presented in book form. Photographic captions are used to illustrate several tasks and could be more widely used, particularly where a skill breaks neatly into a series of component parts.

The guide is organized sequentially so that each task acts as a prerequisite for the next; and within each area, target skills are categorized into sequences, e.g. in the Sensory Motor Section, sitting is sequentially covered in tasks 39-41, and walking is similarly presented in tasks 59-69.

The curriculum has been designed for use by both parents and teachers. Its sequential layout makes it an easy guide to interpret and follow. However a background in teaching strategies will enhance its implementation.

The activities have wide applicability to infants between the ages of 0-2 years who are minimally handicapped, and to children and adults who are severely and profoundly handicapped, operating at a level appropriate to early childhood.

The teaching of each task presents a series of actions. Reading of the guide provides the potential trainer with the necessary training for its successful use. If, however, success is not forthcoming following the implementation of the procedure, the skill of writing further steps is required. Reading of the learning guide alone does not ensure the trainer will acquire this skill.

Further information on how to use the checklist and what steps to take if the task activity is not successful would be helpful. Also the parent needs to be cautioned as to the number of tasks the child should be programmed for at any one time.

Cost: $7.95.

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Pushaw, D.R. *Teach Your Child to Talk: A Parent Guide.* New York: CEBCO Standard Publishing, 1976.

This inexpensive little book is designed as a guide for parents, discussing in detail the stages of language development in the normal baby. The style is simple and interesting, with photographs and numerous lively cartoon illustrations. One section is devoted to the special needs of children with various handicaps. The following chapters each cover a six-month developmental stage, with examples of typical speech, suggested activities to encouage the child. Lots of very relevant information. Useful for parents, teacher aides and teachers with no previous reading or detailed knowledge of early developmental stages, or those working with retarded children.

Cost: $2.95.

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Excerpted from *Special*, December, 1977,
p. 17.

REVIEWS OF MATERIALS FOR PARENTS AND PROGRAM STAFF WORKING TOGETHER

Hanson, M.J. *Teaching Your Down's Syndrome Infant: A Guide for Parents.* Baltimore: University Park Press, 1977.

This guidebook arose from the Down's Syndrome Infant-Parent Program, at the Centre of Human Development, University of Oregon, U.S.A. The twelve families who participated in the project worked with a parent adviser in assessing their child's development and in designing and monitoring teaching procedures.

The introductory chapters of the book include: some results of the project; techniques of behaviour management; approaches to task analysis of behaviours; and methods of recording a child's progress. Developmental milestone charts and associated teaching procedures form the major part of the book.

The milestone charts, which cover the age range of 0-24 months, are based upon the Bayley Scales of Infant Development, the Denver Developmental Screening Test, Gessell Developmental Scale, and the Sewell Early Education Development Program. Development is divided into the following four areas: Gross Motor; Fine Motor; Communication; and Social and Self Help Skills. Each area is further subdivided; for example, Fine Motor consists of visual, reading and grasping skills, object manipulation and problem solving. The age range and expected average age of development is charted for each milestone.

Corresponding to each milestone is a teaching procedure which comprises a written objective, materials required, a task analysis of the skills or, where appropriate, a list of activities, methods of consequation and record keeping.

Organization of Materials: The guidebook is presented in the format of a manual and is well organized. Introductory chapters are followed by the developmental milestone charts which are coded into the four areas of development. A page index system is similarly used to group the teaching procedures.

Use of Instructions: The task analytical nature of the teaching procedures provides the parent or therapist with clear directions on how to present a particular task to the infant. However, a problem that could arise relates to the number of programs appropriate for the parent to conduct at any one time. The manual suggests that a program be chosen from each area of development and practised ten times per day. Even if this were a realistic undertaking, confusion could arise in choosing one area over another, particularly when, for example, Gross Motor has eight subsections. To overcome this problem an outside professional would be required to help assess the child's development with the parent and make a mutual decision on priority areas, numbers of activities and type of recording system to be used. Daily charting of results recommended by the manual [illegible] all parents and [illegible] [illegible]. The manual therefore is most suited to use by an interventer and parent in partnership.

Applicability: The materials are applicable for both parents and professionals. [illegible] milestone charts [illegible] developmental milestones [illegible] applicable for children with types of developmental delay other than Down's Syndrome. Used in conjunction with a home based or centre based program the manual would act as a resource for parents to check the details of activities demonstrated in therapy and educational sessions.

Sequential Development of Content: The program content is well sequenced, being based upon a series of developmental milestones and presented in a task analyzed format.

Training Requirements: In-service training will be minimal if the program is used by or in partnership with a skilled educator or therapist. Practice in using the developmental milestone charts and following the teaching strategies nevertheless is advised. If parents are not involved in a guided program, and are to make maximum use of the manual, they should seek professional supervision in the initial stages of interpretation.

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Bluma, S., Shearer, M., Frohman, A., Hilliard, J. *Portage Guide to Early Education.* Wisconsin: Portage Project, 1976.

The Portage Guide to Early Education comprises three parts:

KAO

(a) a checklist of behaviours based on normal development;

(b) a card index presenting each of the checklisted behaviours with suggested teaching techniques; and

(c) a manual of instructions.

The Checklist

The checklist presents a sequential listing of behaviours across the colour coded areas of: Infant Stimulation, Socialization, Language, Self Help, Cognitive and Motor Skills. With the exception of Infant Stimulation which refers only to 0-4 months age range, the areas present behavioural checklist items for 0-6 years of development.

The items to be checked are behaviourally defined, specifying what the child is required to demonstrate to be credited with a particular item as an entry behaviour. Beside each checklist item is a recording space to indicate mastery of the skill, date achieved and comments. Additional information, e.g. dates of health checks, can be included in the Information Log which is found on the inside of the front page of the checklist.

The Card Index

The card index comprises [illegible] cards which are colour coded and numbered to correspond with the individual item on the checklist. The behaviour item becomes the title of the card and each card lists several activities for teaching the title behaviour.

The Manual

The manual gives directions for use of the checklist and card index; these directions include where to begin testing, when to stop and how to task analyse the title behaviour of an index card for children requiring more teaching steps than those given in the recorded activities.

The manual also presents information on how to write objectives, how to facilitate the prerequisite skills for the learning of attention, imitation and compliance and how to use correction procedures.

Discussion

The colour coding and compact presentation of the materials makes the "Portage Guide to Early Education" easy to interpret and administer. The manual provides clear directions on how to implement the materials. The limiting factor, however, is that there are no directions on how to administer each checklist item. The results, therefore, will not only reflect the level of child functioning, but the skill of the trainer. A list of materials required for use in testing would also expedite the assessment procedure.

The checklist items are finely graded and specified in month age-ranges for young infants. The materials were designed for use with both non-handicapped and handicapped pre-school children. However, the developmental level of the activities makes the Portage Guide relevant for use with older children and adults who are severely handicapped. Although the materials were developed in conjunction with the home based Portage Project, they are equally suitable for centre based programs.

The reading of the manual is essential to the adequate implementation of the Guide. Appropriate use of the materials requires an understanding of:

- where to begin and stop assessment
- how to write behavioural objectives, including criteria and conditions
- how to task analyze the title behaviours of the card index.

It is imperative that those using the Guide understand its limitations and recognize it as a guide and only as a guide to early education programming.

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REVIEWS OF MATERIALS FOR PROGRAM STAFF

Chapel Hill Training Outreach Project Materials. North Carolina: Kaplan Press.

1. Sanford, A.R. *Learning Accomplishment Profile.* North Carolina: Kaplan Press, 1974.

The Learning Accomplishment Profile (L.A.P.) is based upon normative developmental milestones from 0-72 months of age. The profile items are divided into the developmental areas of Gross Motor, Fine Motor, Self Help, Cognitive, Language and Social Abilities.

Administration of the L.A.P. provides the teacher or therapist with :

(a) an analysis of the child's skills
(b) a record of the child's progress
(c) a developmental age for each area and associated rates of development
(d) areas of weakness relating to future curriculum objectives.

2. Sandford, R.A. (Ed.). *A Manual for use with the Learning Accomplishment Profile.* North Carolina: Kaplan Press, 1974.

The L.A.P. manual gives a rationale for the use of the profile; the advantages of the prescriptive teaching model; and instructions on -

(a) how to give each assessment item of the L.A.P.
(b) when to credit each item
(c) when to stop testing
(d) how to interpret the L.A.P. results
(e) how to score a developmental age
(f) how to graph a developmental profile.

3. Chapel Hill Training Outreach Project. *Learning Activities for the Young Handicapped Child.* North Carolina: Kaplan Press, 1976.

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This volume provides a comprehensive set of activity sheets suitable for use with the pre-school handicapped child. It was developed in response to the needs expressed by teachers and parents enrolled in the project's training courses. The activities are divided into the six areas identified in the Learning Accomplishment Profile, and within each area a separate activity sheet is given to correspond with a L.A.P. assessment item.

Each activity sheet gives a step by step procedure for the teaching of the task, a list of supplementary activities and a section for recording progress.

4. Chapel Hill Training Outreach Project. *A Planning Guide to the Pre-school Curriculum: The Child, the Process, the Day.* North Carolina: Kaplan Press, 1976.

The pre-school curriculum is built upon a unit approach and is characterized by -

(a) a different theme for each week and different activities for each day of the week

(b) a daily group lesson presenting a hierarchy of responses (Matching, Object Discrimination, Picture Discrimination) and Association

(c) weekly activities aimed to overcome deficits in the six areas assessed by the L.A.P.

Discussion

Applicability

As the Chapel Hill materials cover normal developmental milestones to 72 months of age, they are particularly suitable for use with pre-school and preparatory primary school children who are developmentally delayed in one or more of the areas assessed by the L.A.P.

The technical nature of the materials, e.g. interpretation of the L.A.P. results leading to programming, requires that they be used by trained paramedical and/or educational personnel. Nevertheless the learning activity sheets are most suitable for parents to use as instruction follow-up sheets within the home setting.

Use of the L.A.P. and the Learning Activities text lend themselves to both home or centre based programs. However, the assessment and programming potential of such materials is optimized when used in conjunction with a multi-disciplinary team approach.

Presentation and Organization of Materials

Each item is presented as a separate publication. The layout within each text permits compact organization of the material e.g. the Learning Activities publication is colour coded into the six areas of development. With the exception of the latter text, all books are bound in a durable form. The loose leaf presentation of the Learning Activities text could be enhanced if the string binding were replaced by a series of metal rings.

The L.A.P. publication would be more economical if the assessment pages included added space for progressive recording of results and comments for more than one child. A 47 page record of one assessment for one child is an extravagance that minimally funded programs would not be able to afford.

Sequential Development of Materials

The L.A.P. and Learning Activities publications follow a detailed developmental sequence across the six areas of development. Although the 44 units of the pre-school guide are not sequentially based, they facilitate overlearning by the use of the same daily format, varying only the content.

Training

Reading of the L.A.P. manual and practice in implementing the materials will provide the necessary training for professional workers in the field of pre-school education to become skilled users of the Chapel Hill materials.

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Cunningham, C.C., Jeffree, D.J. *Working with Parents. Developing a Workshop Course for Parents of Young Mentally Handicapped Children.* Manchester: The National Study for Mentally Handicapped Children, 1971.

Description

Working with Parents presents the design and details of a series of workshops that were organized for 40 parents of mentally handicapped children under five years of age at the Hester Adrian Research Centre, University of Manchester. An outline of the purpose and content of the eleven workshop sessions is given. Topics include psychological aspects of young subnormal children and their parents, the development of young subnormal children, techniques for improving the child's behaviour and early stimulation.

A major objective of the course is to introduce the parents to a model which they can successfully apply when approaching their child's learning and behaviour. Components of the model are -

(a) observation and assessment

(b) selection and analysis of a task

(c) communication and teaching of a task

(d) evaluation.

The booklet outlines each aspect of the above model and the appendices include copies of both the Child Development Charts and the Language Development Charts that the parents are trained to use within the workshop sessions. The Child Development Charts are based on items from known developmental scales, e.g. Griffiths, Bayley, Cattell, Denver, and provide checklist items under the headings of physical performance, social and language skills. The language chart covers the recognized areas of vocabulary, communication, sentence structure, comprehension and imitation.

Other appendices include copies of a handout on how to use reinforcement and the course evaluation sheet with a summary of results.

Discussion

The account of the workshops presented provides personnel working with parents of handicapped children of any age with an excellent model for a parent education program. The low drop-out rate from the classes coupled with the positive evaluation comments by parents who completed the course, reflect the success of the Cunningham & Jeffree model. Aspects of the model that may have been instrumental in its success and should be noted by the potential implementer are -

(a) Workshop groups had a tutor-pupil ratio of 1-10 which allowed for individual as well as group attention.

(b) Precise objectives were stated for the first seven weekly sessions while the last four sessions were spaced by a number of weeks varying from three to nine, in order that parents might discuss difficulties encountered in implementing the model.

Working with Parents is a most worthwhile resource for personnel who are working with handicapped children and adults and their parents, caretakers or advocates.

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Division for the Intellectually Handicapped, Perth.

Irrabenna Early Intervention Service Materials.

Irrabeena is the co-ordinating centre of the Division for the Intellectually Handicapped in Perth, Western Australia.

The Irrabeena materials assess the following skill areas:

(a) Fine Motor

(b) Perceptual Motor

(c) Gross Motor

(d) Self Help: drinking; feeding; undressing; dressing; toileting; cleanliness

(e) Language: receptive and expressive abilities

(f) Socialization

The scales which are in the form of checklist items are used to record progress and make program planning decisions.

Curriculum Cards

Each checklist item is numbered and accompanied by a corresponding curriculum card. The card defines the skill and gives an example which could be used as a test item. On the back of each card is a series of activities suitable for teaching the skill.

Discussion

Organization and Presentation

The assessment scales are xeroxed and the cards, 20 cm x 11 cm in size, are economically presented.

Applicability

Pre-school handicapped children and older children and adults who are severely retarded would benefit from the programming potential of the materials.

Training

Professional training in either education or one of the paramedical professions would assist in administering the assessment scales and cross referencing the curriculum cards for the writing of objectives. The curriculum cards also provide excellent suggestions of activities for parents to follow up or teach within the home setting.

Comment

The resemblance of the materials to the Portage Guide is striking; nevertheless the section on daily living skills is a distinguishing feature. If these materials were to be produced commercially, a training manual would need to be written.

Cost: For further information write : Irrabeena Early Intervention Service,
P.O. Box 441, West Perth. 6005.

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Engelmann, S. and Bruner, E.C. *Distar I Reading Program.* Chicago: S.R.A.,1974.

General Information

Target Population: Children who have skill deficits in basic decoding and comprehension. Method and materials are appropriate for the bright child as well as the underachiever.

Program Materials

The teacher's kit includes the following materials:

(a) Three Teacher Presentation Books: These books specify each activity in each lesson and tell the teacher how to present it.

(b) The Teacher's Guide. This guide explains the program and provides instructions on how to teach it.

(c) The Spelling Book. This book contains spelling lessons, which begin at lesson 50 and continue through the remainder of the program.

(d) The Test Book: Included in this booklet are the Placement Test (for the initial placement of the children) and the Mastery Tests (which measure the performance of the children as they progress through the program).

(e) Copies of the three Storybooks that the children use.

(f) A Teacher's Edition of the Take-Home Books.

(g) A cassette demonstrating the pronunciation of the sounds and how to present tasks from the program.

(h) An acetate page protector to enable you to write on the pages of the Presentation Books when necessary.

(i) A set of group progress indicators to enable you to write on the pages of the Presentation books when necessary.

Student materials include:

(a) a set of three Storybooks (softbound and reusable) for each child. These books contain the stories for lessons 91 to 160.

(b) a set of three Take-Home Books for each child. These workbooks contain written activities for every lesson.

Organization and Skill Content of Program

Distar Reading 1 comprises a series of tracks and formats. A track is a programmed development of a major skill; a format is one step in the programming of the skill.

The Program is organized into the two main tracks of Pre Reading Skills and Reading.

"Pre Reading Skills" has the 6 tracks listed below:

1. Sounds - recognition of sound symbols and producing the sounds.
2. Symbol Action Game - learning to sequence events from left to right.
3. Say the sounds - sounding out a word the teacher pronounces.
4. Sound It Out - sounding out a word from a written one.
5. Say It First - saying the sounds in a word quickly to produce a normally spoken word.
6. Rhyming.

The Reading Track is divided into the two sections of Reading Vocabulary and Story Reading. In Reading Vocabulary the child uses his pre reading skills in decoding his first words. All words that the child requires for story reading are introduced in this track.

Story Reading teaches the child how to read words in sentences, answer comprehension questions and recognize the purpose of punctuation marks.

Take Homes provide exercises in picture completion, sound-writing practice, pattern recognition and matching exercises.

Spelling activities begin with children writing individual sounds from teachers' dictation leading to word and sentence dictation. Spelling words follow the sequence of reading words.

Philosophy of the Instructional Material

According to Engelmann and Bruner (1974) all children can learn if they are taught carefully. Emphasis is placed on not only what is to be taught but how it is to be taught. Methodology used is that of Direct Instruction which involves teaching students strategies for decoding and comprehension.

In line with the philosophy of Direct Instruction the skills of the program are logically sequenced, practised to 100% criterion and taught by the teacher in the exact words and actions specified.

General Critique of Material

(a) Sequence of Material

The skills required to decode and read material are task analyzed and presented accordingly. Each skill builds upon that which preceded it. The Pre Reading activities are sequenced to enable the child to gain those skills necessary to begin decoding words. The reading activities build through single word recognition to the reading of sentences culminating in that of short stories.

(b) Ratio of Teacher/Pupil Involvement in Program

The child and teacher are equally involved in the program. Each lesson is a series of teacher questions, followed by verbal responses from the child either as a member of a group or individually.

(c) Practice of Skills

The program is designed to enable the child to master a skill by presenting it several times in sequence using different examples, but the same format. This facilitates over-learning which is critical to the skill acquisition of the intellectually handicapped child.

Utilization of Teacher Time

The program requires considerable time on the part of the teacher in learning how to use it; practising the verbal cues to promote spontaneous instructions; presenting it on a daily basis for a minimum of 35 minutes. The amount of time involved must be weighed against the needs of the target population. The more handicapped the group the more desirable the program.

Evaluation

The program provides:

(a) a placement list enabling the teacher to start the child at his or her appropriate entry level,

(b) on-going evaluation in the form of Mastery Tests which are administered every 5 days after lesson 10.

The tests serve to give the teacher feedback on the effectiveness of his teaching and suggestions for regrouping.

Classroom Organization

Following the administration of the placement test, children are grouped accordingly. In implementing the program individually to different groups, organizational difficulties could arise if the teacher works unaided. This problem is of particular significance in grades for TMR or EMR children who have limited skills in working independently.

Reinforcement

Authors stress the use of verbal praise throughout the program. Tangibles may be needed for lower level children. Each lesson provides ample opportunity for praise to be made contingent upon correct verbal responses.

Special Features of the Program

Modifications of orthography are made to overcome those anomalies of the English language that tend to confuse the child with learning deficits. For example:

(a) Silent letters in words are written in smaller print, which acts as a cue for the child not to sound them out.

(b) Long vowels in letters are marked with a dash above them.

(c) Double letters that make a single sound are joined.

Suggestions for Implementation

For the program to be successfully implemented with handicapped children the teacher will require an aide or volunteer to either -

(a) supervise the rest of the grade while a Distar session is in progress, or

(b) take a Distar group.

With sufficient training an aide or volunteer could successfully manage the program.

Crucial to its implementation is that the teacher be committed to it on a daily basis and disciplined to conduct it exactly as written. Otherwise the sequence of skills and practice effect required by the child will be interrupted.

Recommendations for Purchase

Before purchasing the program the teacher should be exposed to the philosophy and materials of Distar Reading 1 in order that the cost and time involvement of the program can be measured against the needs of the target population.

Conclusion

Distar Reading 1 presents a systematic way of equipping the handicapped child to decode and read.

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Excerpted from Evaluation of Distar 1 Reading Program, *Special*, May 1977, pp.3-4.

Fredericks, H.D.B. *et al.* *The Teaching Research Curriculum for Moderately and Severely Handicapped.* Springfield, Illinois: Charles C. Thomas, 1976.

If this book had been written fifty years ago, it would almost certainly never have been published - certainly not by a large publishing firm. In fact, its publication is an excellent example of the shifting of attitudes from the passive acceptance of the moderately and severely handicapped to a belief in the efficacy of active intervention. The last two decades in particular have witnessed the successful dissemination of new attitudes and approaches towards the handicapped. And this is reflected in an ever-increasing flow of books containing practical suggestions for the better education of handicapped children. Charles C. Thomas has been prominent among publishers of such books, and it is not at all surprising to find this publisher responsible for the production of a very careful and very detailed curriculum for education of handicapped children.

The target populations for which this book was designed are identified by the authors as the moderately and severely retarded, the deaf, the blind and multiply handicapped children. Teachers of any of these children are offered a detailed set of schedules arranged sequentially as behavioural objectives. To explain how the curriculum as a whole was devised, I cannot do better than quote this paragraph from the first chapter of the book (p.6):

> "The curriculum is first divided into major areas and is organized as follows: (1) Self-help skills, (2) receptive language skills, (3) expressive language skills, (4) writing skills, (5) reading skills, (6) motor skills and (7) cognitive skills. Within each of these major areas there are three possible subcomponents called (1) skills, (2) phases and (3) steps. A *skill* is usually a complex behaviour requiring the acquisition of a number of subordinate behaviours before it is mastered. A *phase* is a further breakdown of that particular larger behaviour, and a *step* is usually a minute breakdown of the phase."

The authors then give examples of how major areas, skills, phases and steps are organized. A major area cited is receptive language. One of the skills to be acquired is maintenance of eye contact. Subsumed under this skill, the authors offer six phases which progress from phase one, "child's face is held in position for eye contact by an adult as he calls the child's name" up to phase six when "child will, when asked to look, maintain eye contact." The steps for each of the six phases are time intervals of one to five seconds for maintenance of eye contact.

The book is presented in eight sections. Section one provides guidelines for curriculum use and the remaining seven sections set out the behavioural objectives for developing skills in the seven major areas. There is an introduction to each section which sets out the curriculum subareas encompassed in each major area. Thus in section eight, entitled "Cognitive Skills Behavioral Objectives" the five subareas in the total curriculum area are number concepts, monetary concepts, time-telling concepts, personal information concepts and musical activities. As well as the introduction, each section contains a variable number of chapters, though section and chapter are sometimes one and the same.

It is, perhaps, not quite felicitous that desired behavioural objectives should be defined as terminal behaviours. Quite apart from unfortunate connotations that this has with "terminal illness" there is a suggestion that once a certain skill is attained by the handicapped child, no further educative program in that area is indicated. Terms such as 'target behaviour','criterion behaviour' or'behavioural goal' would have served the purpose better. In the section dealing with reading skills, there is an assumption - not altogether justified - that prereading skills belong here.

No book with as practical an orientation as this book has can escape such small criticisms as are offered here. Taken in its entirety, the ten contributing authors deserve the highest praise for the painstaking efforts they have taken in translating their own valuable experience into an orderly curriculum for the advantage of other teachers of handicapped children. If there is one thing that teachers of handicapped children appreciate above all else, it is sound, practical, field-tested teaching schedules. And this book offers them exactly that.

Cost: $US 18.90

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Excerpted from *The Exceptional Child*, Vol. 24, No. 2 (July, 1977), pp.117-118.

Gentry, D., and Adams, G. *A Curriculum Based, Direct Intervention Approach to the Education of Handicapped Infants*. In N.G. Haring and D.D. Bricker (Eds.) *Teaching the Severely Handicapped*. Vol. III. Colombus: Special Press, 1978.

In this chapter Gentry and Adams outline how the direct intervention approach (Haring and Gentry, 1976; Haring and Bateman, 1977; Lynch, McGuigan and Shoemaker, 1976) can be applied to educational programming for handicapped infants. The following steps are outlined.

1. Identification and assessment of infants.
   Normative and criterion referenced measures are discussed.
2. Development of a systematic instructional sequence, examplified by the "Behaviour Repertoire for Handicapped Infants" (Gentry, *et al*, 1977).
3. Assessment of the infant's entry level into the instructional sequence.
4. Writing of long and short term objectives to include the three essential components of condition, criteria and task.
5. Writing of program plan sheets, with the required components exemplified by the plan sheet in the University of Washington, Experimental Educational Model.
6. Continuous and long term measurement.
   Examples of data summary and recording sheets are given.

Although Gentry and Haring present direct instruction as an alternative to both stimulation oriented and activity oriented programs, they do not impose it upon the educator as the only approach. Likewise, they acknowledge that more research is required before the results of early intervention can be interpreted as definitive.

The chapter provides the early intervention educator and/or therapist with a systematic model for curriculum development and presentation.

For further information in the area of direct instruction, the educator can be guided by the reference list which is a valuable resource not only in relation to instructional techniques, but also to an understanding of the early learning of handicapped infants.

References:

Gentry, N.D., Adams, G.C., Andrews, M., Chandler, L., Freedman, P., Kelley, J., Livingston, S., Robinson, R., Rusch, J., Soltman, S., Slade, C. and VanderVeer, B. *Infant Learning Program: Behaviour Repertoire for Handicapped Infants*, 3rd rev. Experimental Education Unit, Child Development and Mental Retardation Center, University of Washington, 1977.

Haring, N.G. and Bateman, B. *Teaching the Learning Disabled Child.* New Jersey: Prentice-Hall, 1977.

Haring, N.G. and Gentry, N.D. Direct and Individualized Instructional Procedures. In N.G. Haung & R.L. Schiefelbusch (Eds.) *Teaching Special Children.* New York: McGraw-Hill, 1976.

Lynch, V., McGuigan, C., and Shoemaker, S. *An Introduction to Systematic Instruction.* Working Paper No. 61. Experimental Education Unit. Child Development and Mental Retardation Center, University of Washington, 1976.

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Kent, L.R. *Language Acquisition Program for the Severely Retarded.* Illinois: Research Press, 1974.

This book represents the most systematic and thorough approach seen so far for teachers working with children with minimal or no oral language skills. In particular, the actual content of the vocabulary is extremely relevant to the contexts in which teachers are likely to be working, being based around concepts, activities and the environment of young children's early learning experiences. It should fill a long-felt need in the program planning of the special school or institution.

The Language Acquisition Program represents the culmination of research by the author in conjunction with the Coldwater State Home and Training School, and the Western Michigan University Child Development Center. Earlier versions appeared in McLean, Yoder and Schiefelbrusch (sic): 'Language Intervention with the Retarded', University Park Press, Baltimore, 1972. It is designed to teach a language system to severely retarded children, using principles of reinforcement theory with token rewards, and programmed instruction. The setting out of behavioural goals, of content, sequences, teaching procedures and evaluation is detailed and admirably clear.

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There are three major sections: Pre-Verbal, Verbal-Receptive and Verbal-Expressive.

The Pre-Verbal section covers elementary attending phases such as sitting still, looking at objects, eye-contact, and motor imitation.

The Verbal-Receptive section begins with basic receptive language using pointing responses, (body parts) and, later, performance responses, i.e. responding to commands such as "stand up", "sit down" etc. This is followed by pointing to named objects; finding concealed objects; performance of actions involving body parts; involving objects; involving room parts. The second part of the receptive program is aimed at expanding the vocabulary to include some prepositions; related object pairs (comb-brush); sorting colours; body/space awareness; commands (get in the box, turn round and round etc.); nouns; big/little, big one; numbers; big one/little one; colour plus object, and so on.

The Verbal-Expressive section gives strategies for making the gradual transitions to spoken language based on the vocabulary of the receptive program.

An inventory assists the teachers to evaluate the child's performance to determine entry to the program, and can also be used at various intervals as an assessment instrument. Each training session contains a Test step and a Teach step.

Chapter 6 contains an adaptation of the L.A.P. to deaf signs (American Sign Language) by Dr. Martha Snell, Ph.D., University of Virginia, Special Education Faculty. The manual approach may be deemed useful as an alternative to the oral in cases where -

(a) the child is known to be deaf or hard of hearing and has not responded to oral training;

(b) the child is known to be deaf or hard of hearing, has given some positive response to oral training but, due to his advanced age, needs a functional language system as quickly as possible;

(c) the child, for unknown reasons, has not responded adequately to the expressive aspects of oral training.

The L.A.P. is designed for individual administration, or for a teacher working with two children.

Cost: $5.90

Anne Hoey,
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Special Education Division,
Special Services,
Victoria State Department of Education.

Excerpted from *Special*, December, 1977, p. 17.

V55

Macquarie University. *Down's Syndrome Program Assessment and Curriculum Materials.*

Description: The Macquarie materials consist of an Assessment Performance Inventory, Curriculum Guide, and supplementary program materials. A description of each of the components follows:

1. Assessment Performance Inventory. Revised, 1979. 0-18 months, 18 months to 3 years, 3-4 years, 4-5 years.

Each assessment form lists a series of sequentially developed checklist items organized into the categories of Gross Motor, Fine Motor/Pre-Academic, Language and Personal/Social. The items are developed from an analysis of 16 intelligence and developmental scales (Gross and Cohen, 1974). The pre-academic items are the result of task analyzing the skills that are included in the Macquarie Pre-school and Kindergarten curricula. Where items resemble those of the Denver Developmental Screening Test, the number and category of the Denver item is given. Instructions for administration of the checklist items and criteria for assessment are listed in the curriculum guide.

2. The Curriculum Guide for Intellectually Handicapped Children, 0-4 years.

The curriculum guide is based upon the same developmental sequence as the assessment inventory. An objective, identifying the task, conditions, criteria and teaching procedures, is given for each test item. Suggested teaching procedures include the strategies of modelling, prompting, shaping and reinforcing.

Underlying the curriculum is a prescriptive teaching model. Following the initial assessment a prescription is written programming the child across the same four areas as the assessment inventory. Instruction is data based with daily assessments leading to either redefinition of specific objectives, more practice or, when criterion is reached, moving to the next step in the sequence.

The curriculum is accompanied by a series of supplementary programs. A brief description of each program is given below.

3. Reading Program, Revised, 1979. Authors: Cairns, S. and Pieterse, M.

The program is sequenced through the following five stages:

Stage 1: Early Visual Discrimination: Picture Lotto. A series of graded steps introduces matching selecting and sorting of picture lotto cards through to alphabet lotto.

Stage 2: Word Lotto: These games are sequentially introduced with lotto grids varying in size from 1:1 to 1:6.

Stage 3: Individualized Recruiting Program: The teacher works with the child to construct his/her first reading book.

Stage 4: Structured Reading Program: The child is introduced to his/her first reading series. Teaching examples are given using the Ladybird series of readers.

Stage 5: Phonic Program: Once the child has mastered 50 words, phonics are introduced in the following order:

(a) Sound of single letters

(b) Simple word families

(c) Decoding vowel consonant words

(d) Decoding consonant vowel consonant words

(e) Comprehension.

4. Number Skills Program. Authors: Thorley, B., Woods, V., Pieterse, M. and Cairns, S.

The objectives of the number program are for the child to -

(a) count out a subset of 1 to 10 objects

(b) match sets with printed numerals 1 to 10

(c) count or point to the numerals 1 to 10.

A sequence of objectives is given, the entry skills identified and teaching methods outlined. These include the use of instructions, modelling, prompting, shaping and reinforcement.

The program was developed as part of a research project with eight Down syndrome children, with an age range of 3 to 5 years throughout 1978.

5. Milestones in Motor Development, 0-6 months. Author: Pieterse, M.

The gross motor milestones are identified for the 0-6 months age range and activities given to promote their development. The milestones cover the areas of head control, rolling and sitting.

6. Nutrition and Feeding Programs. Author: Pieterse, M.

The program presents six points on diet and feeding; a diet plan for the pre-school child; some feeding suggestions; and a feeding skills checklist, with associated activities for the 3-35 months age range.

7. Infant Exercises, 0-18 months.

Exercise descriptions are given for -

(a) lying on the back

(b) lying face down

(c) visual responsiveness

(d) auditory acuity

(e) eye-hand co-ordination.

Discussion

As the materials are based upon normal developmental milestones they are applicable to children with developmental delays as well as to children with Down's syndrome.

The materials are mimeographed and individually collated. Cross referencing could be enhanced if the materials were presented in a single edition.

The sequential nature of the Macquarie materials is characterized by the developmental nature of the assessment inventories and the prescriptive approach to suggested teaching methods.

Training in the use of behavioural and instructional techniques would assist the professional to interpret and implement the materials. Likewise viewing videotapes of the Macquarie program or a visit to the centre would help in this respect.

Availability:

For purchase of the materials write to:

Mrs. Moira Pieterse,
Macquarie Down's Syndrome Program,
Macquarie University,
North Ryde, N.S.W.

Patricia M. O'Brien,
Lecturer,
Burwood State College,
Melbourne, Victoria.

Schafer, D.S., Moersch, M.S. (Eds.). *Developmental Programming for Infants and Young Children.* 3 Vols. Ann Arbor: University of Michigan Press, 1977.

These materials have been developed as part of the Early Intervention Project for Handicapped Infants and Young Children at the Institute for the Study of Mental Retardation and Related Disabilities, University of Michigan. The three volumes are entitled:

Assessment and Application	:	Vol. 1
Early Intervention Profile	:	Vol. 2
Stimulation Activities	:	Vol. 3

The profile and stimulation activities are based upon developmental milestones of the 0 to 36 months age range. Areas assessed by the profile are: perceptual/fine motor development; cognition; language; social and emotional; self care and gross motor development. The 274 profile items are designed for administration by a multi-disciplinary team, although one member can be trained to perform the task. Test items are explicit and administration time is approximately one hour. Although the profile has not been standardized on a normal or exceptional population, it has been validated against standardized scales, such as the Bayley Scales of Infant Development.

Assessment and Application, Vol. 1, is aimed to bridge the gap between diagnosis and programming planning. The reader is instructed on how to interpret the profile result for each area of development. The activities listed in Vol. 3 relate to the profile items and would make excellent objectives if conditions and criteria were added. Reading of the materials alone, however, will not ensure an understanding of how to write objectives or teach specific activities. In-service training on programming is required. An additional volume, task analyzing the developmental activities, would add to the usefulness of the materials, as would a listing of materials required for administration of the profile.

The value of the materials lies in the presentation of activities that can be used to bridge the developmental delays identified by the profile items. The multi-disciplinary nature of the materials make them most suitable for application within such settings.

Patricia M. O'Brien,
Lecturer,
Burwood State College,
Melbourne, Victoria.

Užgiris, I.C. and Hunt, J. McV. *Assessment in Infancy*. Urbana: University of Illinois Press, 1975.

In this volume two noteworthy authorities on child psychology, Ina Užgiris, Professor of Psychology at Clark University and Joseph McVicker Hunt, Emeritus Professor of Psychology at the University of Illinois, have combined their talents and insights into child development to produce a novel approach to the assessment of psychological development in infancy.

Piaget's observations of child development and his epigenetic theory combined with other evidence of the hierarchical organization of intelligence have inspired and given direction to the authors in their efforts to produce scales pertaining to six branches of psychological development, namely the development of visual pursuit and the permanence of objects; the means of obtaining desired environmental events; vocal and gestural imitation, operational causality; the construction of object relations in space; and the development of schemes for relating to objects. The ordinal scales devised by the co-authors, which are discussed in the book, are unique in the area of assessment, focusing on infant capabilities during the sensori-motor period of development.

The volume itself is divided into three parts. The first summarizes the theoretical background and reinterpretations of the development of intelligence. Opposing theoretical views are discussed in some detail. Such divergent views as the accretional view of development represented by a strict S-R approach and the transformational view wherein interrelated competencies are transformed to progressively higher levels are explored and evaluated.

Also in this section the assumptions underlying the traditional scales of assessment are examined and found inadequate. The authors compare these inadequacies with the positive elements of the ordinal scales. They draw attention to a number of acknowledged deficiencies including the facts that traditional scales are based on a concept of 'unitary ability' and that these scales are tied to chronological age by the co-occurrence of particular behaviour in a standardized population. In contrast, the authors point out, ordinal scales are based on a concept of a number of abilities consisting of co-ordinations and differentiations within the infant's repertoire. By their very nature ordinal scales emphasize sequence of behaviour and permit no chronological alignment, rather they permit individual assessment of 'how' an infant functions in response to certain environmental circumstances as well as permitting comparison of infants in terms of achievement relatively independent of age.

Within this first section issues pertaining to development are also examined. In particular the notions of maturation or organismic preprogramming and the role of environmental input are considered in detail. Studies of environmental enrichment and deprivation of both animal and human populations are reviewed and examined for the empirical justification they give to the role of environmental determinants in intelligence development.

Finding support from Piagetian theory for their hypothesis of an invariant order in cognitive development and justification for their focus on environmental circumstances for its development, both Uzgiris and Hunt describe their efforts to devise the scales in the second section of the book. The investigation undertaken is described in three phases. Both the determination of eliciting situations and the critical actions of the infants are described and the revisions of the instruments up to the final product. In this section both inter-examiner reliability and inter-session stability of infant actions are examined and discussed. The six scales are then described with explicit explanation of both critical action and eliciting situation.

In the third section the ordinal scales themselves are presented with directions for choice of materials, arrangement of situations, observation and recording of critical actions being clearly delineated. Examples of record forms are also included.

Overall, the book is a significant contribution to psychology in general, and to the field of assessment in particular. Any person interested in child development will benefit from the reading of precise description of behaviour during the first two years of life. Professionals in both psychology and education who recognize the inadequacies of existing assessment instruments particularly in the period of infancy, may find this work provides an appropriate alternative. The significance of the scales lies in the new approach it permits to individual assessment and the means it provides of ascertaining to some extent the influence of various environmental circumstances.

The validity of the particular scales according to the authors is inherent as they represent cognitive organization in sequence and need not be based on any comparative status in a statistical distribution. However the question of the valididy of these scales for an atypical population may be raised. Khan (1976) found the scales to be valid and a useful measure in the assessment of cognitive functioning of both severely and profoundly retarded children. It appears, therefore, that the applicability of the scales is far-reaching. Though the basic material for the scales was devised from observation of a normal group of infants, the scales offer a method for more realistic positive assessment of retarded individuals without the negativistic comparative approach of the traditional scales.

Though, in the authors' view, the work is incomplete in their long-range plan to uncover the differential rates of development associated with differing child-rearing practices, it remains as a challenge to existing assessment practice and a starting point for future psychological endeavour.

Reference:

Kahn, J.V. Utility of the Uzgiris and Hunt Scales of sensori-motor development with severely and profoundly retarded children. *American Journal of Mental Deficiency*, 80, 1976, No. 6.

Wendy Marshall,
Remedial/Resource Teacher,
Queensland Department of Education.

Excerpted from *The Exceptional Child*, Vol. 24, No.2 (July, 1977), pp.123-125.

LIST OF RESOURCES

Commercially Available Materials - Excluding Tests - Used by 3 or More Programs Studied

Portage Guide to Early Education	(38)
Peabody - Language and Gross Motor	(13)
Teaching Your Down's Syndrome Infant - Marci J. Hanson	(7)
Guide to Early Developmental Training - Wabash Centre for the Mentally Retarded., Inc.	(6)
Learning Accomplishment Profile - Chapel Hill	(5)
Macquarie University Down's Syndrome Program Assessment/ Performance Inventory	(4)
Behavioural Characteristics Progression	(4)
Down's Syndrome Project - University of Washington	(3)
Distar Kits	(3)
Ling's Speech Training Program	(3)
Environmental Language Inventory	(3)

( ) Denotes the number of programs listing this material as a resource.

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APPENDIX G

EARLY INTERVENTION PROGRAM SITE VISIT REPORT

to

Royal Victorian Institute for the Blind
333 Burwood Highway
Burwood Victoria

(Research team: J. Elkins, L. Conrad and M. Willis)

August 14, 1979

SUMMARY

The R.V.I.B. early intervention program is an individual program with identifiable parts within a larger agency and is a comprehensive program for a specific disability group. There is substantial family involvement, and the program includes centre only, combined home & centre based and home based only programs.

Age group serviced	0 - 6 years	
Staffing - Regular	Full time pre-school teachers	8
	3 full time and 2 part-time home advisors	5
	full time mothercraft nurse	1
	full time child care workers	10
	full time nursing sisters	4
Consultant/Advisory	Orientation and mobility instructor	- on call
	Speech Therapist	- 1 day/week
	Psychologist	- 1 day/week
	Physiotherapist	- 2 days/week
	Paediatrician	- 1 day/month
Volunteer	Drivers	15

The program is a comprehensive one and aims to develop the "total child". The program would, however, place special emphasis on ego development, sensory integration and language development because of the nature of the children's difficulties.

The program has individual program plans for each child.

Assessment - The main forms of initial and ongoing assessment are the use of checklists and recorded details of direct observation.

- Assessments are made for the specific purpose of referring outside the program.

BACKGROUND

The R.V.I.B. established its school 17 years ago and for the last 8 years has also provided services for the very young handicapped child. Residential care for babies was provided. Five years ago, the recognition of need for support for the families of visually-impaired babies led to home visits by three nursing sisters. These visits were infrequent, but this service was maintained for three years and led to the development of the present early intervention program. The trend of development of R.V.I.B. services for young children has been from a medical perspective to an educational one. The program is a combination home-centre based program with emphasis on total development, and hence the program can be considered a comprehensive one. The program puts a great emphasis on family relationships and the family's involvement in the child's education.

Application to the program is available for any child with visual impairment in Victoria. In practice, the R.V.I.B. program caters primarily for children whose main difficulty is visual impairment, but many of these children are multiply handicapped. The service is available free of cost to the family, and the home-based program is available statewide.

R.V.I.B. provides information below which describes the early intervention program and the procedure for entry to the program.

REFERRING AGENTS

e.g. direct parent contact; general practitioners; nurses; and specialists- particularly ophthalmologists and paediatricians; and welfare officers.

↓

The first contact with the family after referral is made by the home advisors. The home advisors then report to the enrolment panel.

ENROLMENT PANEL

The enrolment panel makes a decision as to whether the R.V.I.B. program has the resources and staff to responsibly manage a program for the child and family. The home advisor then notifies the parents of the panel's decision.

↓

EARLY CHILDHOOD DEVELOPMENT DEPARTMENT

0 - 3½ years

home visiting service
parent relief

playgroups
residential unit for M.H. children
consultancy with other agencies

A family may receive any combination of the above services.

↓

ASSESSMENT PANEL

↓

PRE-SCHOOL DEPARTMENT
3½ - 6 years

R.V.I.B. Kindergarten - day sessions
R.V.I.B. Kindergarten - residential

Pre-school visiting teacher service to local kindergartens. Consultancy service to other agencies, e.g. Spastic Centre, Day Training Centre. Some children attend both R.V.I.B. Kindergarten and local kindergarten with support from visiting teachers.

R.V.I.B. is presently able to accommodate requests for services, but financial considerations are limiting the growth of the program to cater for extra requests and this may restrict the availability of services in the future. Attempts are presently being made to employ another home advisor. The enrolment panel seeks alternative services for any child who is declined permission to enter the R.V.I.B. program. Reasons for refusal of admission to the program are usually associated with "over-servicing" or the existence of a more appropriate program for the child's needs. Some of the children receiving the R.V.I.B. program will also be involved with other services (e.g. National Acoustics Laboratory, Mental Retardation Services, Spastic Society, etc.). Every attempt is made to co-ordinate services with other agencies and overcome the problems associated with "sharing" clients.

ENVIRONMENT/WIDER SYSTEMS

There are no groups in Victoria providing early intervention programs for visually-impaired children other than R.V.I.B. and Monnington School for the Deaf. The Monnington School program does not have a home-based component.

R.V.I.B. receives 100 per cent subsidy from the Health Commission for the eight pre-school staff but relies on the general community and fund raising for the balance of expenses. An annual financial report is available. Attempts have been made to obtain funding from the Office of Child Care, but a reply has not yet been received indicating the success of the application.

The program does not need to have many people participating, other than the staff. The teachers at the school are committed to early intervention and identify problems (e.g. mobility) which might be prevented by early intervention (e.g. finger strength for brailling). Close contact is maintained with Burwood State College and honorary professionals are also used as consultants for aspects of programing at certain times (e.g. music, drama).

Voluntary drivers are used, but generally volunteers are not involved in the actual program. Nor are community groups, such as service groups, used to implement the program. College and university students are involved in both short visits and extended training, observation and practical work. Requests are often received from people doing theses, dissertations and studies in the fields of medicine, architecture, education, etc., to use the facilities of R.V.I.B. A policy has been established of allowing direct contact with children over two years old only if involvement can be full time and for at least two weeks. Burwood State College, because of its proximity and its interest in the R.V.I.B. program, has recently conducted a study to ascertain the incidence of severe visual difficulties in Victoria.

CLIENTS

The Children

Like all such programs, the R.V.I.B. roll varies at different times of the year. However, the roll figures at the time of the site visit in

August were considered by staff members to be close estimates of the usual number of children currently receiving the program.

	Home-based Component	Centre-based Component ↓	Integrated Home/ Centre-based	Total
Handicapped boys	42	6	10	58
Handicapped girls	43	5	5	53
Handicapped children aged Under one year	15	-	-	15
1 - 2 years	15	-	-	15
2 - 3 years	21	-	7	28
3 - 4 years	13	3	4	20
4 - 5 years	7	4	2	13
5 - 6 years	14	4	2	20
Non-handicapped children	-	(Siblings & others in community) 5	-	5
Hours per week spent on average by children served	Metrop. * 1.5 hrs Country .75 hrs	18	Home component 1.5 hours Centre comp. 12 Total: 13.5	
Hours per session spent on average by children served	1.5 .3	3	3	
Sessions per week	Metrop. 1/week Country 1/month (.25/week)	6	4	

* depending on need.
↓ including 3 residentials.

Although the program caters predominantly for children with visual impairment, increasingly the program is serving children more appropriately labelled as multiply handicapped. The majority of the children could be categorized as multiply handicapped.

Family

When a child is referred to the program, the home advisor makes the initial contact with the family and has about an hour-long interview with the parents. Children who enter the program at an early age and who live close to the R.V.I.B. Centre will have close contacts with the home advisory program until the child is about 3½ years of age. Then, although contact will be maintained with the home advisor, the pre-school program will become the main contact with R.V.I.B. Children who are referred to the program at a later age (e.g., migrant children) may have less contact with the home advisory program and have their first contact with R.V.I.B. at preschool. The age of the child and the geographical location of the child's home are the main factors influencing which components of the program the child and family receive and hence the amount of contact maintained with the family. Home visiting occurs at a statewide level for home-based components of the program, and there is a bus provided by R.V.I.B. for transporting metropolitan children to the centre. Some parents drive their children to the centre.

A three hour Monday afternoon program for parents of home-visited children is held weekly. The afternoon includes one hour without staff for parent-parent interaction and then a two hour session with staff (group therapy, parent effectiveness workshops and workshops on creative media, etc.). For children attending the centre-based component of the program, parent contact is maintained by parents' visits to the centre with the child for one hour per week. The purposes of contact with the parents are family support, training, and reporting of information about the child's progress.

The parents' role in the program is at all levels of involvement - as providers of input to decision making about the child and the program, as teachers at home, as participants in the program at the centre and as supporters of each other as parents. The parents do not have a parent organization as such but, at a recent parent evening, sixty parents attended. As yet the parents have not actually initiated formal meetings for such purposes as discussion, learning or mutual support, but the parents have suggested topics for their regular formal meetings.

STRUCTURE

Staff

The types and numbers of regular, consultant/advisory and volunteer staff are listed below:

Regular Staff

Preschool Teachers*	8	Full time
Home Advisors	5	Full time (3); Part-time (2)
Mothercraft Nurse	1	Full time
Child Care Workers	10	Full time
Nursing Sisters**	4	Full time

Consultant Advisory

Orientation and Mobility Instructor	1	on call
Speech Therapist	1	1 day a week
Psychologist	1	1 day a week
Physiotherapist	1	2 days a week
Paediatrician	1	1 day a month

Volunteers

Drivers	15
Music Lecturer	1
Movements Lecturer	1

* including Early Intervention and Preschool Co-ordinator

** these do not interact with children

The home advisors have an interesting diversity of professional backgrounds and experiences. Although they tend to work in geographical regions, the wide range of skills they have among them allows for an ease of exchange of information. One is a pre-school teacher and psychologist, another a teacher, another a pre-school teacher and teacher of deaf children and another a psychologist and audiologist. All regular staff members are female.

A high priority is placed upon in-service training for staff members and as much time as two hours per week is often given to in-service courses. Topics concerning play and interpersonal relationships have been recent areas of focus. Encouragement is also given for staff to attend courses outside R.V.I.B. For example, one home advisor has recently attended a course on family therapy run by the Mental Health Department.↓

Buildings

The setting of the pre-school component of the R.V.I.B. early intervention program is part of the total R.V.I.B. building complex. The rooms are used exclusively for the purposes of the program. The staff are very

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↓ In 1981 the Early Intervention and Pre-school Co-ordinator is to attend an international symposium on current approaches to the visually impaired child's needs.

aware of the limitations of the outdoor area in front of the building for outdoor activities, but it is presently being redesigned. It was originally the type of outdoor area designed to enhance the attractiveness of the building from the street. The pre-school centre has many small offices with similar doorways down a long corridor opposite the group area for the children. The building is acknowledged to be poorly designed for use by visually-impaired children. The group area for children is functional but far from ideal, and the staff have tried to minimize the limitations of the building as much as possible.

The staff are very aware of the limitations of the environment for providing a program for the children. The rooms are not quite wide enough, and the glass down the side of the corridor provides constant distractions and disruptions to the continuity of a program when staff and visitors use the corridor. The noise factor is also a problem because of the design of the building and the glass and floor covering in particular. According to staff, a one-way glass viewing area for a parent room would definitely be a useful addition to present facilities. The group area for the children has a quiet room (which can also be used for behaviour difficulties), small group areas, doll play area, cubby, mirrors and wash basins in addition to those in the toilet area. Outside there is a good covered outdoor adventure playground. Although more equipment is needed and funds are presently being sought for buying more equipment, there is enough equipment available to put the playground to functional use.

Transport

Most families use private cars. The volunteer driver system provides a service for parents who cannot transport their children. The staff did not know of any parents who may be experiencing transport problems. Trams close by provide a local transport service and the mini bus is used for trips to beach, zoo etc. Taxis may be used in special cases at R.V.I.B. expense.

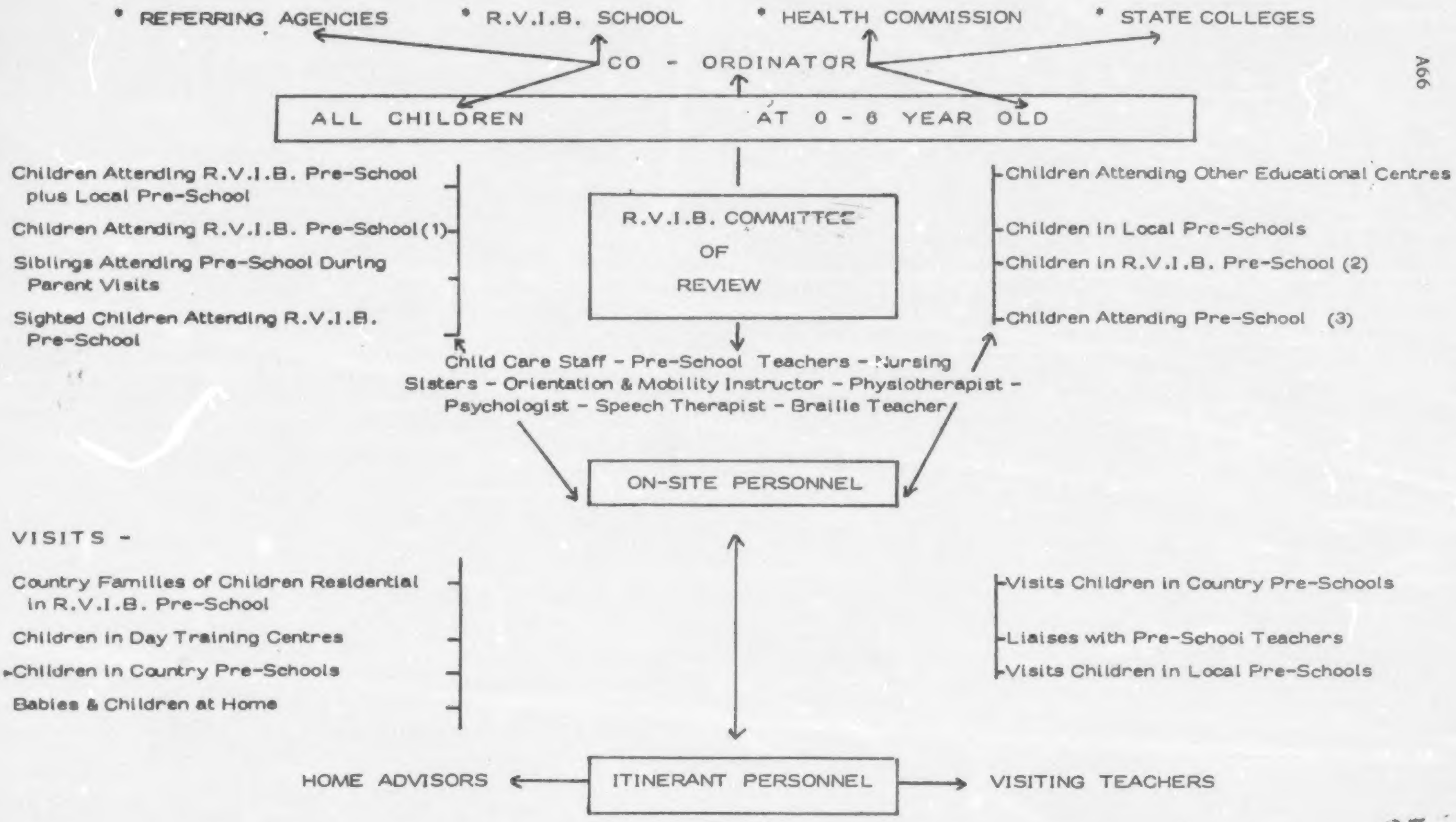
Hierarchical

See attached chart.

Communicating

Most of the communicating of information about the services of the R.V.I.B. program takes place at an informal level, usually as part of contact with families, other agencies etc. The staff feel they are catering for virtually all the children who presently need their service in Victoria. There are several handouts available describing the R.V.I.B. services, enrolment procedures, etc. Contact with other agencies tends to be via "shared" clients and hence a lot of communicating occurs at this informal level. Since the research team's visit, posters and pamphlets publicizing the need for early medical and educational intervention have been prepared.

ROYAL VICTORIAN INSTITUTE FOR THE BLIND EARLY CHILDHOOD DEVELOPMENT DEPARTMENT



REFERRING AGENCIES
R.V.I.B. SCHOOL
HEALTH COMMISSION
STATE COLLEGES
CO - ORDINATOR
ALL CHILDREN AT 0 - 6 YEAR OLD
Children Attending R.V.I.B. Pre-School plus Local Pre-School
Children Attending R.V.I.B. Pre-School (1)
Siblings Attending Pre-School During Parent Visits
Sighted Children Attending R.V.I.B. Pre-School
R.V.I.B. COMMITTEE OF REVIEW
Children Attending Other Educational Centres
Children in Local Pre-Schools
Children in R.V.I.B. Pre-School (2)
Children Attending Pre-School (3)
Child Care Staff - Pre-School Teachers - Nursing Sisters - Orientation & Mobility Instructor - Physiotherapist - Psychologist - Speech Therapist - Braille Teacher
ON-SITE PERSONNEL
VISITS -
Country Families of Children Residential in R.V.I.B. Pre-School
Children in Day Training Centres
Children in Country Pre-Schools
Babies & Children at Home
Visits Children in Country Pre-Schools
Liaises with Pre-School Teachers
Visits Children in Local Pre-Schools
HOME ADVISORS
ITINERANT PERSONNEL
VISITING TEACHERS

A66

PROCESS

Children enter the centre-based component of the program from two main sources, and the procedure for contact with the child and family will vary depending upon which source.

(1) Some children enter the pre-school via the home advisory service at about two or three years of age. The children come initially with their mothers for an hourly session each week, and then attendance is gradually built up. The teacher liaises with the home advisor who will know the child and family very well, and every attempt is made to maintain continuity of contact between home advisor and family, even after the child is attending the pre-school frequently.

(2) When children are referred directly to the centre-based program and there has been no prior contact with the home advisory service, contact is made with the family by the home advisor and the same procedure as above is then followed.

The main forms of assessment used throughout the program are checklists (such as the Revised Development Checklist and Oregon Project Skills Inventory) and recorded descriptions from direct observations. Consideration is being given to possibly using Bayley Scales for future assessments. When the child enters the program, reports from medical sources have to be sent for, and often there is time lag from the time the child enters the program until the time when information from other agencies is collected. The main source of information about the child will be from the home advisory service if the child receives the home-based component of the program.

Individual records are kept of each child's progress, and the checklists and records of observation are kept in each child's file. The home advisors keep records of each contact with the families and record details of the child's progress, equipment left with the family, and further action needed. Records of some visits may be only one or two sentences, and at other times further notes may be needed. Medical, and ophthalmological reports are also filed for reference when programing.

Referrals of new clients to the program come from a wide range of referring agents. However, the most common sources of referral are public hospitals and parents. When a referral is made, the first person from R.V.I.B. to make contact with the parents of the child is usually the home advisor. When the parents make the referral, a recent report from an ophthalmologist is required as soon as possible after the referral.

If a child enters the program while still a baby, the home advisors will be the family's main R.V.I.B. liaison person. The home advisors see their jobs as consisting of three main roles:-

(1) To help parents see themselves as their child's best educators, acknowledge their feelings about their child's handicap and to provide educational guidelines to help the parents work with the child at home, understanding delay in developmental milestones anticipated when visual impairment is present.

(2) To provide a consultant/liaison service with other community facilities, e.g. speech therapy, spastic centre etc.

(3) To be a consultant for other agencies, e.g. day training centres.

Contact with the families is initially once a week for families living close by and about once a month for families living in rural areas. The rural home visits tend to last for a longer period of time than the more frequent urban home visits. The home advisory service provides consulting and educational roles. Emphasis on either aspect depends on the individual family's needs. Although the home advisors tend to have assignments by geographical region, the wide range of skills they have in the home advisory service means that interchange of special skills and knowledge is possible whenever needed.

When a child starts the centre-based component of the program, the child may already have an individual file from the home advisory service. As part of the pre-school program, the observational details recorded are likely to be details about the child's cognitive development as manifested in visual/perceptual skills, fine and gross motor skills, language and speech and social skills, and adult-child interactions, etc. Approximately each month, skills are listed for each child. "A step by step learning guide" by Vicki M. Johnson and Robert A. Werner, Syracuse University Press, 1975 is used as the main guide for the multiply handicapped children's pre-school program. However, all programs are individual and based on observation of the child's needs with programs drawn from a variety of sources.

The staff noted how their philosophy regarding the concept of play is often different from that of parents in the initial stages of contact with the parents. Some parents apparently find it stressful that the children use toys in "wrong" ways. Emphasis in the program is placed on teaching the parents to understand how children learn through play, how to establish a play area and on discussing differences between "structured" and "fun" play. The parents are helped to provide a stimulating environment, working co-actively, and to provide sensory stimulation and language models.

The program operates for the same period as the school year. Although the program closes for the holidays, no break is longer than 4 weeks. A relief service is often arranged in crisis situations and there is a holiday service for children who are wards of state (in total care).

Lending equipment to the parents is part of the home advisor's role, and this occurs almost from the time of first contact with the families. The equipment is catalogued and a list of equipment is available. The equipment includes "cause and effect" equipment, fine motor equipment, tactile stimulation equipment and also specifically designed equipment such as high chairs which may be borrowed over a longer period of time. Noah's Ark Toy Library is also used for parent selection once a month.

The program uses the comments of individual staff members and informal feedback from parents as a means of evaluating its service. The frequent contact that is maintained with families means that written reports and formal parent interviews are considered unnecessary. Written reports are presented regularly as case studies.

The staff view their needs at the moment as being an extension of the home advisory service so that the service to rural families can be maintained and possibly extended. Shortage of staff means that the time factor is the main limitation and it is a weakness in the program which the staff would like to be able to change.

Of great importance is the fact that members of the staff are presently involved in the establishment of a "resource group for the visually handicapped" and are working on a directory of services throughout Australia. Concern was expressed by staff that the Australian and New Zealand Association for Teachers of the Visually Handicapped Conference being held in New Zealand in January was placing no emphasis on early intervention. The staff at R.V.I.B. were involved in arranging seminars about early intervention in May next year instead and have expressed their concern to the organizers of the New Zealand Conference.

NORMALIZATION

The PASS checklist was used as a method of assessing the degree of normalization which the Royal Victorian Institute for the Blind program is able to achieve for the children in its program. The fact that the program has both home-and centre-based components means that for many items on the PASS checklist each component of the program has to be rated separately.

For instance, the home-based component of the program has to score highly for normalization principles regarding the physical details of the building and surrounding neighbourhood. The centre-based program takes place in a building which is part of the large R.V.I.B. complex and hence is an institutional type setting, and the centre-based program thus scores at a low level for aspects of social integration of the program. Some of the details which result in a low score in the area are unimportant in themselves but they add to a total public image which prevents the children from being considered like other children in the community. The R.V.I.B. label itself also stresses the "handicap" of the children.

The centre-based program scores highly for normalization principles related to staff-child relationships, and the program itself, in the sense of the staff's approach to the children's development, scores highly. The program also scores highly for its ties to academia via students and links with Burwood State College. On program evaluation the program does not score at a level as high as that of other items on the PASS checklist.

In conclusion, the staff are doing their best to minimize limitations, in the normalization sense, placed upon the centre-based program by the building, location and the name of R.V.I.B. Given the limitations of the physical resources of building, location etc., the staff are applying the principles of normalization to a high degree throughout the whole program. The home-based program can score no more highly than it does, since the home is ultimately the most normalizing environment for a young child.

APPENDIX H

LIST OF EARLY INTERVENTION PROGRAMS IDENTIFIED BY THE SCHONELL EDUCATIONAL RESEARCH CENTRE

The following list of early intervention programs and their addresses is based upon lists of programs identified by us as early intervention directly serving handicapped children at the time of the 1980 workshops. Since that time some programs have been discontinued and we have learned of the existence of others. We attempted to gather questionnaire data on the latter and, where we were successful in so doing, the programs have been added to our list.

NEW SOUTH WALES

A.C.L.D. Pre-school Program
(Association for Children with Learning Difficulties)
St George Centre
Forest Road & Hugh Avenue
Peakhurst 2210

Allowah Babies' Hospital
8 Perry Street
Dundas 2117

Armidale & New England Hospital
(Health Commission)
Rusden Street
Armidale 2350

Baby Stimulation Program & Pre-school Program
Special Education Centre
Newcastle C.A.E.
Rankin Drive
Waratah 2298

Bexley Therapy Centre
(Health Commission)
15 Broadfoot Street
Bexley 2207

Broderick School for Crippled Children
NSW Soc. for Crippled Children
Chalmers & Bedford Sts
SYDNEY 2000

Child Development Program
New England Ed. Diagnostic Centre,
Armidale 2350

Child Study Centre
Kuring-Gai C.A.E.
Eton Road
Lindfield 2070

Cooinda Playgroup for Special Children
Woodstock
Diggers Road
North Albury 2640

Developmental Stimulation Program for Infants
Royal Alexandra Hospital for Children
Camperdown 2050

Down's Syndrome Program
Macquarie University
Balaclava Road
North Ryde 2113

Early Education Clinic
Baby Health Centre
Paraween St & Langley Avenue
Cremorne Junction 2090

Early Intervention Program
Intellectually & Physically H'capped Children's Assoc.

Bambi Private Nursing Home
144 Memorial Avenue
Liverpool 2170

Hoxton Park School
88 Gloucester Road
Hurstville 2220

Early Portage Intervention Project
Illawarra Health Region,
(NSW Health & Y.C.)
Baringa Hospital,
21 Mt Ousley Rd
Fairy Meadow 2519

Education Department
Greenacres Road
Woolongong 2500

Education Department
Westhaven Public School
Palmer Street
Dubbo 2830

Enfield H-V Developmental Program
Child Development Unit
Royal Blind Society of NSW
4 Mitchell Street
Enfield 2136

Grafton Special Needs Playgroup
Playgroup Centre
Westward Park
Bacon St 2460

Handicapped Children's Playgroup
(Health Commission)
Community Care Centre
4A Keene Street
Cessnock 2325

Hearing Impaired Program
Guidance & Special Education
(Education Department)
North Sydney 2060

Home Management Program
Autistic Children's Assoc of NSW
Vern Barnett Diagnostic
Teaching Centre
41 Cook Street
Forestville 2087

Hornsby & Kuring-gai Health Service
Hornsby 2077

Illawarra Soc for Crippled Children
362 Crown Street
Wollongong 2500

Manly-Warringah School for
Crippled Children
NSW Soc for Crippled Children
Chalmers & Bedford Streets
Sydney 2000

Marsden Early Intervention Program
(Health Commission)
Laurel House Assessment &
Resource Centre
Marsden Rehab Centre
Marsden St
Paramatta 2150

Miroma Pre-School
Miroma Rudolf Steiner School
8 Village High Road
Vaucluse 2030

Parent Guidance/Itinerant
Teachers of the Deaf
Catholic Centre for
Hearing-Impaired Children
59 The Boulevarde
Strathfield 2135

Play and Learn Service
(Health Commission)
Community Health Centre
17 York Lane
Taree 2430

Pre-school Counsellor &
Special School for Multiply
Handicapped Blind Children
The Royal NSW Institute for
Deaf & Blind Children
361-365 North Rocks Rd
North Rocks 2151

Southern Tablelands Child
Development Unit
(Health Commission)
126 Cowper Street
Goulburn 2580

Special Need Playgroup
Community Health Centre
38 Gordon Street
Coffs Harbour 2450

St Gabriel's School for the Deaf
Old Northern Road
Castle Hill 2154

St Lucy's School for the Blind
Wahroonga 2076

"Stimulus" Early Development
Program for Preschoolers
Richmond Public School
Windsor Street
Richmond 2753

Sub-normal Children's Welfare
Assoc. Playgroups
8 Junction Street
Ryde 2112

Tangara S.S.P
(Education Department)
Bong Bong Street
Mittagong 2575

The Lorna Hodgkinson Sunshine
Home School
212 Pacific Highway
Gore Hill 2065

The Shepherd Centre
The Council for Integrated Deaf
Education
University of Sydney
Sydney 2006

The Spastic Centre of NSW
189 Allambie Road
Allambie Heights 2100

VICTORIA

Audiology & Preschool Centre
Advisory Council for Children with
Impaired Hearing (Vic)
137 Blackburn Rd
Blackburn 3130

Australian Centre for
Brain Injured Children
15 Powlett Street
Mordialloc 3195

Broad Insight
St John's Ambulance Brigade Hall
Pascoe Vale Road
Vacana 3047

Dinah & Henry Krongold Centre
for Exceptional Children
Monash University Faculty of Ed.
Clayton 3168

Noah's Ark Toy Library
28 The Avenue
Windsor 3181

Early Childhood Development
Programme (SW Region)
Victorian Health Commission
173 Koroit St
Warrnambool 3280

Early Education for Hearing
Impaired Children
John Pierce Centre
169 Glen Ena Road
Ripponlea 3183

Early Intervention Program
Spastic Society Chelsea
Nepean Highway
Aspendale 3195

EPIC Children's Centre
Preston Institute of Technology
Plenty Road
Bundoora 3083

Frankston Special Developmental
School
Victorian Special Ed Dept
32 Cranbourne Rd
Frankston 3199

Handi-Help Playgroup
Brunswick Council
12 Hunter Street
West Brunswick 3055

Intervention Unit
Royal Children's Hospital
Flemington Road
Parkville 3052

Kallemondah SDS
Victorian Special Educ Dept
Tallarook Street
Seymour 3660

Kalparrin Pre-school for
Handicapped Children
1 Church Avenue
Greensborough 3088

Kankama Day Training Centre
Mornington & District
I.H. Person's Welfare Assoc
Horsham 3400

Malvern Playgroup for
Handicapped Children
Uniting Church Hall
13 Spring Rd
Malvern 3144

Mansfield Autistic Playschool
Kitchen Street
Mansfield 3722

McCallum House Early Intervention
Programme
Ballarat Mentally Retarded
Children's Welfare Assoc
Sebastapol Street
Ballarat 3350

McDonald House School for
Deaf Children
Edwards Road Flora Hill
Bendigo 3550

Melton Special Developmental School
Victorian Dept. of Education
"Djerriwah"
Melton 3337

Monkani Centre for Mentally
Handicapped
Dixon Avenue
Croydon 3136

Monnington Centre
Victorian Education Dept
15 Adeney Avenue
Kew 3101

Moorabbin Day Training Centre
Moorabin Assoc for the
Intellectually Handicapped
"The White House 1 Anne Street
McKinnon 3204

Mulleraterong Centre for I.H.
Children & Adults
Alexandra Parade
Hamilton 3300

Nobel Park Special Developmental
School
Victorian Dept. of Education
41-43 Callander Road
Noble Park 3174

Numurkah Special Developmental
School
Victorian Dept. of Education
O'Connor Street
Numurkah 3636

Oakleigh Special Developmental
School
Victorian Dept. of Education
1 Renver Road
Clayton 3166

Parent Guidance for Profoundly
Hearing Impaired Children
625 Swanston Street
Carlton 3053

Peter Harcourt Centre
Havlin Street
Bendigo 3550

Pre-kindergarten Home Visiting
Service & Playgroups
Yooralla Society of Victoria
Nylex House 10 Queens Road
Melbourne 3004

Pre-schools & Visiting Kindergarten
Teacher Service
Yooralla Society of Victoria
Nylex House 10 Queens Road
Melbourne 3004

Princess Elizabeth Jnr. School
for Deaf Children
90 Elgar Road
Burwood 3125

Shannon Pk Early Intervention Project
Spastic Childrens Soc. of Victoria
Balcombe Rd & Shannon Avenue
Newtown 3220

Shepparton Toy Library Playgroup
C/- Special Education Unit
150 Hayes Street
Shepparton 3630

Sunshine House Early Parental
Intervention Program
Sunshine Helping Hand Assoc
121 Tallintyre Road
West Sunshine 3020

Tehan House
Echuca & District Intellectually
Handicapped Childrens Assoc
High Street South
Echuca 3625

Wallara Day Training Centre Early
Intervention Programme
Dandenong & District Mentally
Retarded Childrens Welfare Assoc
36 Potter Street
Dandenong 3175

Wattle House Day Training Centre
Maryborough Mentally Handicapped
Childrens Welfare Assoc
20 Christian Street
Maryborough 3465

West Gippsland Centre for
Retarded Children
48 Mason Street
Warragul 3820

Windarring Day Training Centre for
Intellectually Handicapped
Baynton Street
Kyneton 3444

Yarrabah Special Developmental
School
Education Dept. of Education
64 Nepean Highway
Aspendale 3195

QUEENSLAND

Cairns West Special Pre-school Unit
Qld Dept. of Education
Cairns West State School
Hoare Street 4870

Catholic Educational Centre for
Deaf Children
117 Agnew Street
Norman Park 4170

Central Assessment Clinic
Intellectually H'capped Services
Dept. of Health
"Biala" 270 Roma Street
Brisbane 4000

Child Language & Behaviour
Therapy Programme
C.H.I.L.D.
"Glenleighden" Cubberla Street
Fig Tree Pocket 4069

Cootharinga State Special School
Townsville 4810

Early Education Support Group
Dept. of Education Wide Bay Region
Special Education Centre
164 Woodstock St
Maryborough 4650

Early Intervention Program
Acacia Special Pre-school Unit
Chardean Street
Acacia Ridge 4110

Early Intervention Program
Aspley Special Pre-school Unit
Horn Road
Aspley 4034

Early Intervention Group
Autistic Childrens Therapy Centre
Cnr Jackson & Hellawell Roads
Sunnybank Hills 4109

Early Intervention Program
Kenmore South Special Preschool
Glenfrew Street
Kenmore 4069

Early Intervention Program
Mt Gravatt Special Pre-school Unit
Nursery Road
Mt Gravatt 4122

Early Intervention Programme
Spina Bifida Assoc of Qld
387 Old Cleveland Road
Coorparoo 4151

Infant Stimulation Programme
QSNCWA
14 Jordan Terrace
Bowen Hills 4006

Mackay Early Childhood Intervention Programme
Department of Education Special
Education Unit
Cnr Pinder & Ferguson Streets
Mackay 4740

Narbethong School for Visually
Handicapped Children
Department of Education
Cnr.Churchill & Salisbury Streets
Buranda 4102

Pre-school for Hearing Impaired
Department of Education
Special Education Unit Leichardt
Ward State School
North Street
Rockhampton 4700

Special Education Pre-school Unit
Department of Education
Assoc for the Pre-school Education
of Deaf Children
O'Loan Street
Yerongpilly 4104

The North Qld Society for Crippled
Children
Warburton & Landsborough Streets
Townsville 4810

The Qld Spastic Welfare League
Oxlade Drive
New Farm 4005

Townview Special Education Unit
Department of Education
Townview Primary School
Mt Isa 4825

W.R.Black H'capped Childrens Centre
Uniting Church Special Caring
Services, Laurel Avenue
Chelmer 4068

Xavier Hospital for Children
388 Cavendish Road
Coorparoo 4151

Barkuma
Central Districts Mentally H'capped
Childrens Assoc. Inc.
Coventry Road
Smithfield Plains 5114

Bresle House Day Care Centre
Flinders Medical Centre Dept of
Paediatrics
Bedford Park 5042

Developmental Learning Programme
for Young Down's Children
Down's Children Inc.
Adelaide College of Arts & Educ.
Holbrooks Road
Underdale 5032

Home Liaison Officer Service
(Orana)
The Mentally Retarded Childrens
Society of SA Inc
61 Unley Road
Parkside 5063

IRS Activity Advisor & Physiotherapy
Service
Intellectually Retarded Services
Branch
Cramond House 2 Prescott Tce
Toorak Gardens 5065

Integrated Playgroup
Education Dept / Intellectual
Retarded Services
Mansfield Pk Jnr Primary School
Dudley Street
Mansfield Park 5012

Kent Town Pre-school
Education Department
Fullarton Road
Kent Town 5067

Port Pirie Handicapped & Retarded
Childrens Centre
Port Pirie Dist Hospital Inc
Alexander Street
Port Pirie 5540

Regency Park Centre (K'garten)
The Crippled Childrens Assoc of SA Inc
Days Road
Regency Park 5010

"Seawinds" Day Care Centre for
Totally Dependent Children
Adelaide Central Mission Inc.
(Uniting Church)
Kate Cocks Memorial Family
Services Inc
46 Wattle Avenue
Hove 5048

Suneden School
Suneden Retarded Childrens Welfare
Association Inc
McInerney Avenue
Mitchell Park 5043

The Community Based Program
The Autistic Children's Assoc
of SA (Inc)
3 Fisher Street
Myrtle Bank 5064

Townsend Pre-school for Hearing
& Hearing Impaired Children
Education Department
Smith Avenue
Hove 5048

Whyalla Early Childhood Resource
Centre
84 Lockhart Street
Whyalla 5600

Woodville Spastic Centre
SA Spastic Paralysis Welfare Assoc
98 Woodville Road
Woodville 5011

WESTERN AUSTRALIA

Child Development Centre
WA Public Health Dept
16 Rheola Street
West Perth 6005

Early Childhood Services Branch
Education Dept of WA
1186 Hay Street
West Perth 6005

Early Intervention Program
Catherine McCauley Centre
Station Road
Wembley 6004

Early Intervention Program
Sutherland Blind Centre
Sutherland Avenue 6062

Exceptional Childrens Project
University of WA Child Study Ctre
Mounts Bay Road
Crawley 6009

Hearing Assessment Centre
Education Dept of WA
Johnstone Street
Peppermint Grove 6011

"Irabeena"
Mental Health Services Division for
the Intellectually Handicapped
53 Ord Street
West Perth 6005

Royal Western Australian Institute
for the Blind
151 Guildford Road
Maylands 6051

Spastic Welfare Assoc of WA Inc
40 Rookwood Street
Mt Lawley 6050

The Speech & Hearing Centre for Deaf
Children WA (Inc)
Dodd Street
Wembley 6014

White Gum Valley Special School
Preschool
Stevens Street
White Gum Valley 6162

TASMANIA

Afternoon Group
Lady Gowrie Child Centre
17 Runnymede Street
Battery Point 7000

Afternoon Group
Education Department
Warrane Kindergarten
Cambridge Road
Warrane 7018

Early Intervention Program
Douglas Parker Rehab Centre
31 Tower Road
New Town 7008

Early Intervention Program
Bruce Hamilton School
Elmsleigh Road
Moonah 7009

Education Department, Tasmania
St Michaels School
22 Hoblers Bridge Road
Launceston 7250

Kindergarten
Lady Rowallan School
231 Campbell Street
Hobart 7000

Language Unit
Lady Rowallan School
231 Campbell Street
Hobart 7000

Language Intervention Programme
Education Dept (Northern Region)
Speech Pathology Clinic
160 St John Street
Launceston 7250

Miranbeena
Royal Childrens Welfare Assoc
Pre-education & Training Centre
306 Mount Street
Burnie 7320

Motor Development Program
Education Department
C/- Assessment Centre
Albuera Street Hobart 7000

Parent-Baby Group
Dept.of Health Services, Tasmania
"Elonera" Handicapped Childrens Ctre
Kelham Street
Launceston 7250

TASMANIA (Cont)

Quindalup Day Training Centre
Mental Health Services
43A Pirie Street
New Town 7008

St Giles Home
Soc. for Care of Crippled Children
65 Amy Road
Launceston 7250

NORTHERN TERRITORY

Down's Syndrome Association of N.T.

Early Intervention Program for Hearing Impaired Children
Education Department
Stuart Park School
Nudl Street
Darwin 5790

AUSTRALIAN CAPITAL TERRITORY

ACT Schools Authority
Special Education Section
Macarthur House
Northbourne Avenue
Lyneham 2602

David St Therapy Centre
(Health Commission)
David Street
O'Connor 2601

Hartley St Centre Pre-school
Turner 2601

Koomarri Special School
56 Dryandra Street
O'Connor 2601

Malkara Special School
Wisdom Street
Garron 2605

Preschool Program
Cranleigh School
Holt 2615

APPENDIX I

SITE VISIT INTERVIEW/OBSERVATION GUIDELINE

VISIT REFERENCE DETAILS: Researchers:

Date:

Name of program:

Name of organization:

Address of program: Building
Street
Suburb/Town
State Postcode: Phone:

Address of organization (if applicable):

Building
Street
Suburb/Town
State Postcode: Phone:

Personnel providing information:

Name	Position

Areas observed:

Specifics of Program(s) Observed:

Date:
Time:
Location:
Type:
Client:
Client Type:
Relationship to total program:

Areas of coverage during interview:

- Background
- Environments/Wider System
- Clients
- Structure
- Process
- General/Opinions

Materials mailed to Schonell Centre:

Materials collected by the research team:

A82

CODE I - BACKGROUND INFO. DESCRIPTIVE COMMENTS/NOTES

1. How would you describe your program?
   a) Home-based; centre-based; integrated H/C; combination H/C
   b) Specific development area; comprehensive developmental area

2. Could we check the history of the program?
   In what year did your program begin to offer services (even in experimental or pilot stages)?
   What led to its beginning?
   Lobbying by parents; formal needs assessment; an informal study of needs; efforts initiated by sponsoring organization.
   Was there some particular person/group involved?
   Where there particular stages in its history that stand out?
   Has your program changed since it started?
   If so, what type of changes occurred?
   What effects did these changes have?

3. How would you describe the size of the geographical area served by your program?

4. How would you describe the objectives of the program?
   Firstly, what are the broad goals you are trying to achieve?
   If there are a number of aspects of the total program, what are your goals for each one?

5. Do you have any policy statements which cover the following? (If no written statements, please describe what your policy is)
   a) The functioning of your program.
   b) Eligibility to receive services.
   c) Duties of staff.

6. If you cannot accommodate all requests for your services how do you decide which children will be served?
   Do you ever make exceptions to your rules? If so, on what grounds?

7. Do you have any written statement on the rights of handicapped children and/or their parents? Yes/No.
   If yes, copy.

8. a) Do your clients make use of services provided by other organizations (e.g. diagnostic services, short-term relief)?
   b) If so, do you have a policy with regard to the use by your clients of services provided by (other) government departments or (other) organizations?
   c) If so, what coordination or communication occurs between your program and such other organizations?
   d) If so, is there an emphasis on the same goals by you and the other organization, or are there differences?

CODE II - ENVIRONMENT(S)/WIDER SYSTEM INFO. DESCRIPTIVE COMMENTS/NOTES

A. Network

1. Are there any groups/organizations serving similar age group and/or disability with whom you have on-going contact? If so ... (2 - 4)

2. Could you provide any information on the services provided by these groups/organizations?

3. What are the general objectives of these groups/organizations?

4. What is the relationship of your service to these groups/organizations?

B. Resources

1. Can you please provide full details of the funding of your program (Source(s); Method(s) of obtaining funds). Have you tried to get funding from any particular source and been unsuccessful? If so, do you know why? Do you have a financial statement that we can take with us?

2. Personnel
   We'd like to talk with you now about the people participating in the program other than those who are employed by your own program.
   Do you have any outside consultants/advisers/therapists who participate in your program?
   If so, why do you have these people as consultants/advisers - do they have special expertise? (Number; Roles; Purpose/frequency of visits; Organization to which they belong; Records kept by these people and availability to staff; Meetings - what purpose? who calls meetings? how often? regular or irregular? who directs meetings)
   Do you make use of volunteers other than parents?
   If so, can you answer some questions about these volunteers?
   What role/s do they play in the program? (Note: check to see if different roles are played by different voluntary workers)
   How do you go about securing their services?
   What characteristics do you have in mind when you accept volunteers?
   Where do most volunteers come from?
   Do you have any details on the use you make of volunteers in your program? (Numbers; Frequency; Duties).
   Do you have a training program for volunteer workers?
   Why? Why not? If yes, who does the training?

3. Community Support
   In your program do you make use of groups in the community (e.g. service clubs, church groups, high school students)?
   If yes, could you tell us about what they do?

4. Student Trainees
   Do any colleges or universities place their students with your program?

If so, are the students involved in short visits or extended training? (Type; Number; Institution(s) Involvement - Observation - Practical).

5. Research Component (External)
Do you have any outside researchers making a study of your program or doing research on your clients?
- Identify groups conducting research
- Identify type of research undertaken to date
- Identify policy/procedure governing outside research

Do parents have a role(s) in the outside research program?
If yes, is this entirely voluntary or are they required to play this role in order to have their children participate in the program?

III - CLIENT

A. Child

We're interested in checking on the numbers and kinds of children served by your program.

1. How many children are participating in your program? (Handicapped girls; handicapped boys; total of handicapped children at the age of under one year - 1-2 years - 2-3 years - 3-4 years - 4-5 years - 5-6 years - non-handicapped children (total only))
How many children have as their primary disability: mental retardation; a physical disability; a hearing disability; a visual disability; multiple handicaps (no primary disability distinguishable)?
Other (please specify).
If any children have more than one disability, would you tell us how many cases there are of each disability in your program?
(You would count a child with hearing and visual handicaps two times, once for each disability):
Cases of mental disability; Cases of physical disability; Cases of a hearing disability; Cases of a visual disability; Cases of other disabilities (please specify).

2. On average what is the total number of hours per week spent by the children served by your program?
On average, what is the number of hours per session spent by the children served by your program?
On average, what is the number of sessions participated in by the children served by your program?

B. Parents/Family

1. Can the parents of the children in your program be described as predominantly belonging to any particular kind of group? If yes, what kind of group? (Income or socioeconomic group; occupational group; social group; ethnic group; religious group).

FACT SHEET ON CHILDREN SERVED BY THE PROGRAM(S)

Looking at your program components in terms of the settings (see definition below), please fill in Table 1 with the appropriate numbers.

For the following table, these definitions will apply:

A. Home-based = all or most direct training offered by the program occurs in the child's home.

B. Centre-based = all or most direct training offered by the program occurs in a centre (whether a permanent facility or a mobile unit).

C. Integrated Home/Centre-based = a program offering a balanced combination of Home and Centre services to the same children or families.

Note: Combinations of the above three groups also exist: for example, a service may provide a home-based program for a group of 20 children, a centre-based program for another group of 20 children, and an integrated program for a third group of 20 children.

Table 1

	Home-based Component	Centre-based Component	Integrated Home/ Centre-based	Total
Handicapped boys				
Handicapped girls				
Handicapped children aged				
Under one year				
1 - 2 years				
2 - 3 years				
3 - 4 years				
4 - 5 years				
5 - 6 years				
Non-handicapped children				
Hours per week spent on average by children served				
Hours per session spent on average by children served				
Sessions per week				

FACT SHEET ON CHILDREN SERVED BY THE PROGRAM(S)

Looking at your program components in terms of content or development areas, please write the name of the content area in the columns (up to 3 possible) and fill in the appropriate numbers in the rows of Table 2. (Examples of content areas: cognitive, sensori-motor, social/emotional, playgroup, language, speech, stimulation, comprehensive).

Table 2

Handicapped boys				
Handicapped girls				
Handicapped children aged				
Under one year				
1 - 2 years				
2 - 3 years				
3 - 4 years				
4 - 5 years				
5 - 6 years				
Non-handicapped children				
Hours per week spent on average by children served				
Sessions per week				

CODE III - CLIENTS (contd) INFO. DESCRIPTIVE COMMENTS/NOTES

Do you know how many children are in the largest family served by your program? If yes, how many?
Do you know how many children are in the smallest family served by the program? If yes, how many?
Can you estimate how many brothers and/or sisters the children in the program have, on average?
If yes, how many?
*Can you estimate how far away from the Centre, is:
The closest family served?
The most distant family served?
*How are most children transported to the Centre?
*Is the cost of transport the responsibility of parents? If not, who pays this cost?

(The asterisked questions apply only to programs with a centre-based component)

2.-3. Do you have an initial interview(s) with the parents before or during the time a child is entering the program?
If yes, please describe the interview. (Nature; duration; frequency).
Do you have any contact with the parents of children in your program?
If so, what kind of contact? (regular or sporadic; brief or lengthy; written (newsletter, progress reports) or oral (telephone, face to face)).
What is the purpose of contact with parents?
Do parents visit you at the Centre, or do you visit parents in the home?
Do you contact parents as individuals or in groups?
How do you make arrangements for contact with parents?

4. Are parents involved in your program(s) at all?
If yes, how do you view the parents' role in your program? (Providers of input to decision-making on child; providers of input to decision-making about programming; caretakers at centre; teachers of own children at home; participants in program at centre; supporters of each other as parents; playmates of children).

5. Do the parents of the children served by your program have a parents' organization?
If yes, can you describe it for us? (purpose, type, numbers; relationship to program operation).

6. Does your program initiate organized group meetings or workshops for parents of children in the program?
If yes, can you describe the meetings or workshops?
(Why are they held? How is information circulated about them? How often are they held? How long do meetings last? Who directs the meetings?)
If your program has a centre-based component, can parents drop by informally at their convenience, or are there particular times when planned visits are appropriate?

7. Do parents ever initiate formal meetings for such purposes as discussion, learning, or mutual support?
If yes, can you describe these meetings? (Why do they meet? How often? Who organizes and controls them? How is information circulated about them?)

CODE	III - CLIENTS (contd)	INFO.	DESCRIPTIVE COMMENTS/NOTES

Do parents ever meet informally with each other?
If yes, can you provide details or examples?

8. Do parents ever exert pressure or offer encouragement to continue programs or establish new ones? If yes, can you give us some details or examples?

A STAFF DATA FORM WAS INSERTED TO PERMIT COLLECTION OF THE FOLLOWING INFORMATION, WHICH WAS BASED UNDER THREE CATEGORIES, E.G. REGULAR, CONSULTANT/ADVISORY AND VOLUNTEER:

Name; Job title; Job description; Qualifications (including any expertise in activities, such as music, art, drama, etc.); In-service training; Status of position (Full. Part (hrs); Sex; Age; Length time in present job; Previous related employment/experience; Any disability).

CODE	IV - STRUCTURE	INFO.	DESCRIPTIVE COMMENTS/NEEDS

A. Physical

1. Physical description of building
   - Pre-school, - Rooms,
   - House, - Hall, - Other.

2. Is the building used exclusively for the program or shared with other users?
   - Exclusive use, - Share
   (Building, Outdoor area, Other facilities).

3. (a) Draw a sketch plan showing permanent space areas and estimate dimensions (perhaps use other side of page).

   (b) Describe the physical accesses into the building and program areas.

   (c) Describe the type of dividers used to provide program areas (e.g. fixed, movable).

4. (a) Group area
   - floor, - table and chairs,
   Individual/small group areas, Doll play area, Cubby, Time-out area for behaviour problems, Trampoline/climbing apparatus, Water play area, Sand play area, Mirrors, Wash basins (in addition to those in toilet area), Other.

   (b) - Office, - Work office (preparation space), - Relaxation areas (lunch), - Visiting professional area, - Other.

CODE	IV - STRUCTURE (contd)	INFO.	DESCRIPTIVE COMMENTS/NOTES
	(c) - Kitchen, - Toilets/wash basins/showers/bath, - Storage area (for equipment/materials) - note how easily accessible, - Sick-bay/resting, - Access of outdoor spaces with indoor (spill over), - Other.		Describe any other areas.
	(d) - Climbing frame, - Balance logs, - Tunnels, - Tyres, - Swings, - Other.		Describe outdoor areas.
	(e)		Describe arrangements made with space to make provision for specific program activities that do not have permanent program space. Also describe the primary purpose of usage for specific areas of demarcation.
	(f) (I) For program - Type, - Amount, - Fixed/movable, - Storage arrangement. (II) For maintenance/operation - Typewriter, - Duplicator, - Other (specify) (III) Who decides on what equipment and materials are required and what procedure is followed in order to obtain desired equipment materials?		Describe the type of equipment and materials (in general terms) that are available for use.
	5. Site Location How would you describe the type of families who live in the surrounding area? - City - high density/dense, - Suburb - dense/scattered, - Town, - Rural.		
	6. Transport (a) What modes of transport are used by clients? - public transport; - special services provided by clients; - client private resources (own car, car pool, walk). (b) Do any parents experience transport problems? (c) Do you know of any children who are excluded from the program because of transport difficulties?		

CODE IV - STRUCTURE (contd) INFO. DESCRIPTIVE COMMENTS/NOTES

7. Other Services

What are the other relevant services which are in immediate proximity to this centre?
- Community general services
- Other services for disabled people
- Other education services for preschool children.

B. Hierarchical

1. Do you have any organizational charts giving details about how your centre is organized administratively?

2. Regular staff (special attached forms).

C. Reports — Covered under background

D. Communicating (likely to be some overlap with I,II,III)

1. With Environment
Publicity about the program

(a) General public
Is the public made aware about the function and services offered? (Yes/No).
If yes, how? (Word of mouth; Brochures; Promotion week; Advertisements-Radio/Television; Other).

Are efforts made to reach out into the community to improve the image of the agency and its clients?

(b) Potential clients
- What procedure is followed to make contact and provide information for potential clients?

(c) Related services
What other services are kept informed of what you offer and to whom you offer your program?

What procedure is followed in making these contacts?

(d) Knowledge of population in NEED but not being reached.
Do you think your program is not reaching some children?
If so, why are some clients being reached?
What information do you have on those not receiving service?
What other services (programs for handicapped children) are they likely to be in?
How do you identify those not receiving your services?
What attempts, if any, have you made to contact/include these people?

2. With Parents — Information obtained within Clients and Process.

CODE IV · STRUCTURE (contd) INFO. DESCRIPTIVE COMMENTS/NOTES

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3. Regular Staff

(a) Inservice
What inservice programs are available to staff? (- Types, - Frequency, - Purpose)

Who sponsors inservice programs?

Has any member of your staff attended a conference or seminar outside the centre this year?

(b) Meetings
What types of staff meetings do you hold?

How frequently do you have meetings?

(c) Case Discussions

Do you have case discussions?
If so, how frequently are they held?

When are parents involved?

What is the procedures for selection of children for case discussion?

V - PROCESS

A. Planning

1. What is the procedure used for dealing with new clients?

Does a parent interview take place at this point?
If so, does the interview involve both parents?

Which staff members are usually included in the interview?

Are any forms of assessment made of the child's development at point of entry to the program?
If so, what forms of assessment are made?

Which staff members are involved?

Which particular assessment instruments are used?

What records are kept of forms of assessment?

What information is likely to be already known about the child's development at the point of entry to your program?

From what sources would the information be available?

How is the information obtained by your staff?

What is the range of sources for referral of children to your program?

What are the most common sources?

Is it required that the parents refer their child via any particular source?

CODE	V - PROCESS (contd)	INFO.	DESCRIPTIVE COMMENTS/NOTES

2. We need as much information as possible about the specific components of your program. Do you have any written description of your curriculum that we can look at, or would you prefer to describe the details of each program area?

   Are there any aspects of development that you see as the main focus of your program?

   What range of developmental areas do you see your program as covering?

   Could you give us as many details as you can about specific programs which you implement for the children.

3. How many weeks of the year does your program operate?

   How many hours per week does your program operate?

4. Do you have a time-table we can look at?

3. How do you determine the program for each child?
   - individual program, - group program,
   - developmental area of program.

   What forms of ongoing evaluation do you use for changing and developing each child's program?

   Are there able to arrange for supplementary services from other agencies for children with particular needs?
   If so, what kinds of services and from what agencies?

   Are any of your children at the moment receiving outside services that your staff recommended for the children?

These questions apply ONLY to programs with a home-visiting component.

4. What are the purposes of the home visits?

   Who makes the home visits?

   How often are they made?

   How long do the visits tend to last?

   What do you see as the value of these visits?

5. Can you give us detailed information about roles and duties of each staff member (full-time, part-time and voluntary)?

6. How does your program relate to other services to your clients in the surrounding area?

CODE V - PROCESS (contd) INFO. DESCRIPTIVE COMMENTS/NOTES

7. Does your program lend equipment or materials to the children and/or families served by your program?
   If so, can you give some details?
   - procedures (formal, informal)
   - kinds of equipment or materials
   - frequency of use.

8. Is there anything about your program that you think is unusual or different from other similar programs?

B. Operating

1. For programming, how do you group your children or assign staff to work with individual children?

   How do you allocate your staff time for various weekly activities or programs?

   How do you organize the use and placement of equipment?

2. What areas of space do you use for each aspect of your program?

   What types of equipment do you have?
   How is the equipment used?

3. Does your staff have any particular unified approach to interaction with the children?

4. What behaviour management techniques are used in your program?

5. What do you see as the value or purpose of play in your program?

   Would you consider all your staff to have the same views about the value of play?
   If not, what differences of opinion may exist?

   What would you think the parents see as the value of play?

6. Do many of your parents have access to a toy library?

C. Monitoring and Control

1. Does your program use any particular methods of evaluating its services?

2. What details of the child's progress are recorded?

   Do you use any particular checklists/tests, etc?

CODE V - PROCESS (contd) INFO. DESCRIPTIVE COMMENTS/NOTES

Do you keep documents of the child's progress which have been collected by other agencies (e.g. Central Assessment Clinic, etc.)?
If so, what sort of information do these agencies provide?

3. Do you have any means of gathering information about the child's relationship with his family/care givers?
If so, what means do you use?

Are there any relationships within the family upon which you focus your attention?

How would you describe the relationship between your staff and the children's parents?

4. What is the pattern of your contact with parents in the centre setting?

Do you arrange interviews with the parents at the centre?
If so, how frequently? Who would be present at these meetings? How long would they be likely to last?

How do you communicate details about each child's progress and needs with the parents?

Do you have written reports for parents?

These questions apply only to programs with a centre based component

5. Research Component (Internal)
Are any of your staff members making a study of your program or doing research on the children in the program?
- Identify staff conducting research
- Identify type of research undertaken to date
- Identify policy/procedure governing research.

Do parents have a role(s) in the internal research program?
If yes, is this entirely voluntary or are they required to play this role in order to have their children participate in the program?

VI - GENERAL QUESTIONS - OPINIONS

A. DIRECTED

1. Any specific problems/needs?

2. What are main strengths of program?

3. What are main weaknesses/problems of program?

CODE	VI - GENERAL QUESTIONS- OPINIONS	INFO.	DESCRIPTIVE COMMENTS/NOTES
	4. What are the main needs → to ensure continuation of program → to enable further development?		
	5. Are there any questions that we should have asked? Do you have comments on areas we have not touched on?		
	B. OPEN		

APPENDIX J

TABLES OF BASIC INFORMATION ON PROGRAMS

The following tables are based on questionnaire data supplied by programs. For each state, programs are listed alphabetically by program name; information on each program included: (1) the number of children in the program; (2) their age; (3) their primary disabilities; (4) the number of children receiving a home-based, centre-based, and integrated home-and centre-based service; and (5) the number of full and part-time staff in various disciplines (teacher, physiotherapist, occupational therapist, speech therapist, psychologist, social worker , and other). The hours of staff involvement, although requested in the questionnaire, do not appear here.

Programs sometimes provided only estimates. For this reason there may occasionally be inconsistencies between totals and subtotals.

Numbers of nonhandicapped children or older children (above the age of six) are included in totals only when it has not been possible to exclude them on the basis of information provided. Where possible, available information on breakdowns of the totals has been provided in brackets in the "Other" column.

NEW SOUTH WALES : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
A.C.L.D. PRE-SCHOOL PROGRAM, PEAKHURST	14		6	8						14			14	2					1	
ALLOWAH BABIES HOSPITAL (Residential)	19	10	9		5	13			1				19	1	1					1 Assistant
ARMIDALE & NEW ENGLAND HOSPITAL	13	1	4	8	7	6					4	8			2	2	1		1	1 Paediatrician
BABY STIMULATION PROGRAM & PRE-SCHOOL PROGRAM (NEWCASTLE C.A.E.)	79	34	22	23	18	52	1		4	4		44	35	4	1		1	1	1	1 Cooordinator 1 Psychiatrist
BEXLEY THERAPY CENTRE	178	81	70	8	59	90			8	2	5	150	7	2	2	2			1	1 Aide/Dev.Officer
BRODERICK SCHOOL FOR CRIPPLED CHILDREN (Pre-School Program)	10		1	9	8				2			10		2	2	2	1	1	1	3 Aides
CHILD DEVELOPMENT PROGRAM (NEED CENTRE)	25	4	11	10	1	22	1		1		13	7	5		1	1	1			1 Community Nurse
CHILD STUDY CENTRE (KURING-GAI CAE)	8	2	6			7			1		1	5	2	1						Teacher trainees
COOINDA PLAYGROUP FOR SPECIAL CHILDREN	11		4	7		9			2			11			1	1				
DEVELOPMENTAL STIMULATION PROGRAM FOR INFANTS (Royal Alexandra Hospital for Children)	15	10	5		3	9				3		15			1	1				
DOWN'S SYNDROME PROGRAM (MACQUARIE UNIVERSITY)	21	7	8	6		21					7	14		3	1					
EARLY EDUCATION CLINIC, CREMORNE (MACQUARIE UNIVERSITY)	170	12	155	3		55				115		170		2	2		1			1 Clerk
EARLY PORTAGE INTERVENTION PROJECT (BARINGA HOSPITAL)	66	34	28	4	2	60			3	1	50		16					1		3 Nurses

PROGRAM NAME	No. chil-dren	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
ENFIELD H.V. DEVELOPMENTAL PROGRAM (Royal Blind Society of NSW)	121	27	29	65			115		6		108	1	12	1	1	3		2	2	
GRAFTON SPECIAL NEEDS PLAYGROUP	6	1	5		2	3		1					6		1	1	1			1 M.R. Training Officer
GREENACRES S.S.P.	81		1	80		24			57			40		12						9 Vol. Aides
HEARING IMPAIRED (Guidance & Special Ed)	132	13	55	64				132			6	126		63				5		Liaison with Audiologist and Med. Officer
HOME MANAGEMENT PROGRAM (Autistic Chn's Assoc.)	16		7	9		2			11	3	16			2				1	1	2 Teacher Aides
HORNSBY & KURING-GAI AREA HEALTH SERVICE	72	31	21	20	3	66				3		72			1	3	2	1	1	1 Driver
ILLAWARRA SOCIETY FOR CRIPPLED CHILDREN	42	5	6	31	17	20			5		3	35	4		1				1	1 Physio.Aide Nursing Staff
INTELLECT. & PHYS. H'CAPPED CHN'S ASSOC.OF NSW (Bambi Private Nursing Home)	64		8	56		64					63	1								Detail not recorded
INTELLECT. & PHYS. H'CAPPED CHN'S ASSOC,OF NSW (Hoxton Park School	12		12						12			12		4						
MANLY-WARRINGAH PLAY-GROUP (M-W. School for Crippled Children)	7	2	4	1	7							7			1	1			1	
MARSDEN REHAB. CENTRE (Laurel House)	9		9			9						9			3	1				
MIROMA RUDOLF STEINER SCHOOL, VAUCLUSE	11		6	5		3			8			11		2	1					1 Music Ther: 1 Eurythmist 1 Masseuse

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T	S.T.	Psych.	Soc.Wk.	Other
PARENT GUIDANCE/ ITINERANT TEACHERS OF THE DEAF (Catholic Centre or Hear.Impaired Chn.)	11	4	5	2				11				3	8	2						
PLAYGROUPS - SUBNORMAL CHILDREN'S WELFARE ASSOCIATION, RYDE	202	46	127	29	41	111	9	5	17	19		202		4	3	2				1 Supervisor 1 Nurse
PRE-SCHOOL COUNSELLING & SPECIAL SCHOOL FOR MULTI-HANDICAPPED BLIND CHILDREN, N.ROCKS	55	8	28	19			6	3	46		34	9	12		2		1	1	2	1 Principal 1 Teacher-Librarian
ST. GABRIEL'S SCHOOL FOR THE DEAF	12		5	7				10	2				12	2						1 Secretary/ Teacher Aide
SOUTHERN TABLELANDS CHILD DEVELOPMENT UNIT	177	6	15	157							43		43		1		1			2 Nurses
SPECIAL NEEDS PLAYGROUP	12	3	3	6	4	7				1			12			2	1			1 Counsellor 1 Secretary
STIMULUS EARLY DEVELOPMENT PROGRAM FOR PRE-SCHOOLERS	16	4	7	5	1	10	1					12		1			1			(4 siblings not h/c ages not recorded)
TANGARA S.S.P.	5			5	1	4						5		1	1	1				3 Teacher Aides
THE LORNA HODGKINSON SUNSHINE HOME SCHOOL	10		4	6		10						10			1		1			Large medical staff in institution
THE SHEPHERD CENTRE (UNIVERSITY OF SYDNEY)	26	3	18	5				26			8	18		6					1	1 Supervisor 2 Student Teachers of Deaf

VICTORIA : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
AUDIOLOGY & PRE-SCHOOL CENTRE "TARALYE" (AD.C. FOR CHN.WITH IMP.HEAR.)	25	4	15	6				25					25				1	1	1	1 Audiologist 1 Technician 1 Orthoptist
AUSTRALIAN CENTRE FOR BRAIN-INJURED CHILDREN	72	13	23	36	44	26				2	72									1 Clin.Director (26 chn. are 6+)
BROAD INSIGHT	14	0	6	8		14					1		13	2						
COUNSELLING, GUIDANCE & CLINICAL SERVICES (EDUC.D.), FOOTSCRAY	6	0	3	3		5			1			6						1	1	
EIP AND PRE-SCHOOL (R.V.I.B.) BURWOOD	111	30	48	33			55		56		85	11	15	8	1		1	1		1 Paediatrician 10 Ch.Care.Wks. 5 Home Adv. 5 Nurses 1 Orient.& Mobity Instructor
EARLY EDUCATION FOR HEARING-IMPAIRED, JOHN PIERCE CENTRE	2	1	1					2				2		1						
EPIC	82	33	29	20		82						82		7	2	1	1	1	1	1 Aide
FRANKSTON SPECIAL DEVELOPMENT SCHOOL(EDUC	9	1	6	2		5			4			9		1	1					
HANDI-HELP PLAYGROUP, BRUNSWICK	15	2	6	7	2	11			1	1		15		1	1			1	1	1 Aide-Interpreter (2 chn, are 6+)
KALLEMONDAH SDS (EDUC)	1		1			1						1			1					
KALPARRIN PRE-SCHOOL FOR HANDICAPPED	35	6	18	11	2	33						35		9	2					1 Psych. 1 Soc.Worker (1 child 6+)
KARKANA D.T.C. HORSHAM	3		3			1			2			1	2		1		1			

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
McCALLUM HOUSE EIP BALLARAT M.R. CHILDREN'S WELFARE ASSOCIATION	16	8	5	3		12			4			1	15	2	1	1	1	1	1	1 Paediatrician 1 Dentist
McDONALD HOUSE SCHOOL FOR DEAF CHILDREN	22		2	20				21	1				22	2					1	1 Teachers Aide (16 chn. are 6+)
MALVERN PLAYGROUP FOR HANDICAPPED CHILDREN	16	2	13	1	8	8						16			1	1	1			
MANSFIELD AUTISTIC PLAY SCHOOL	23		3	20		23					13		10	5						2 Staff Members Travel (20 chn. 6+)
MELTON SDS (EDUC)	7	1	4	2		6			1				7	1						
MONKANI D.T.C. FOR MENTALLY HANDICAPPED	10	2	6	2		8			2				10	1						1 Physio.Asst.
MONNINGTON CENTRE (EDUC)	154	All under 4½				14	21	110	7	2		154		6	1		1	8	3	1 Welfare Off. 2 Librarians 1 Audiologist 1 Interpreter 1 Medical Off.
MOORABBIN DTC, MOORABBIN ASSOC.FOR THE I/H	4		4			4							4	1						1 Sensory/Motor Teacher
MULLERATERONG CENTRE FOR I/H CHN. & ADULTS	4		2	2	1	2			1			4		1	1					
NOBLE PARK SDS (EDUC)	7	3	3	1		6			1				7	2	1			1		1 Welfare Off.
NUMURKAH SDS (EDUC)	6	3	2	1	1	5						6		1						1 ECD Visiting Nurse
OAKLEIGH SDS (EDUC)	15	3	12			15						11	4	3	1			1		
PARENT GUIDANCE FOR PROFOUNDLY HEARING IMPAIRED CHILDREN, LINCOLN INSTITUTE	22	2	3	17				22				22					2			2 Audiologists 1 Student Speech Therapist

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
PETER HARCOURT CENTRE, BENDIGO	8	0	3	5		8							8	2						1 Teachers' Asst.
PRINCESS ELIZABETH JNR. SCHOOL FOR DEAF CHILDREN, BURWOOD	74	0	8	66				60	14			74		20	1		1	2	1	6 Child Care Staff (20 chn. 6+)
ST. PAULS SCHOOL FOR BLIND & VISUALLY HANDICAPPED	73	1	5	67			38		35			73								(60 chn. 6+)
SHANNON PARK EIP SPASTIC CHILDRENS SOCIETY	17	6	10	1	3	11			2	1		17		1	3	2	2	1		1 Aide
SPASTIC SOCIETY, CHELSEA	46	11	26	9	23	18	1		4		1	45		1	7	3	4		1	(1 child is 6+)
SUNSHINE HOUSE EARLY PARENTAL INTERVENTION PROGRAM, SUNSHINE HELPING HAND ASSOC.	17	2	4	11		17					1		16	2	1			1	1	All disciplines available Nursing Staff
TEHAN HOUSE, ECHUCA & DISTRICT I/H CHILDREN'S ASSOCIATION	4	1	0	3		4						4		2	1					
WALLARA DTC EIP DANDENONG & DISTRICT M.R. CHILDRENS ASSOC.	15	8	7			8			7		6		9	2	1	1		1		
WATTLE HOUSE DAY TRAINING CENTRE, MARYBOROUGH M.H. CHILDREN'S WELFARE ASSO	2	2				2							2	1	1					
WEST GIPPSLAND CENTRE FOR RETARDED CHILDREN	1			1					1				1	1		1		3	1	Teachers of Vis. Impaired
WINDARRING DTC FOR I/H CHILDREN	8	1	1	6		5				1		8		2						1 Mental Def. Nurse: (1 ch.6+ 2 chn.not h/c)

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
YARRABAH SDS (EDUC)	3		2	1		1			2			3		1				1		1 Welfare Off.
YOORALIA SOCIETY PRE-SCHOOLS & VISITING KINDERGARTEN TEACHER SERVICE	97		22	75	67	19		1	8	1		97		10	4	3	2		2	2 Medical Offs. 13 Kindergarten Assts. 1 Sp.Th.Aide (6 chn. 6+) (1 child not h/c)
YOORALIA SOCIETY PRE-KINDERGARTEN HOME VISITING SERVICE AND PLAYGROUND	25	10	15		11	6			3		1	24		2	3	3	1		2	2 Medical Offs. (5 chn. not h/c)

QUEENSLAND : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. chil-dren	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
ACACIA RIDGE SPECIAL PRE-SCHOOL UNIT	31	4	5	10		22			4	5	1	28	2	2	2	1	2			1 Medical Off. 1 Guidance Off. (5 chn. not h/c.)
ASPLEY SPECIAL PRE-SCHOOL UNIT	23		7	16		17			2	4			23	2	2	1	1	1		1 Medical Off.
CAIRNS WEST SPECIAL PRE-SCHOOL UNIT	10	1	5	4			1	6		3	2	7	1	1			1			1 Visiting Teacher 1 Teacher's Aide
CATHOLIC EDUCATIONAL CENTRE FOR DEAF CHN.	27	1	6	3				27			3		24	2						Figures recorded exactly as provided by centre.
CENTRAL ASSESSMENT CLINIC	427	147	157	123		427					259	16	152	1	3	2	3	2	2	1 Res.Care Worker All disciplines
COOTHARINGA STATE SPECIAL SCHOOL	23	1	12	10	5				18			23		3	1	1	1			(1 child 6+)
EARLY EDUCATION SUPPORT GROUP (MARYBOROUGH)	7	1	6		1	2		1		3		7		1			1			1 Guidance Off.
EARLY INTERVENTION GROU (Autistic Children's Therapy Centre)	12	1	6	5						12	1	9	2	2	1	1	1	1		1 Paediatrician
EARLY INTERVENTION PROGRAM (Spina Bifida Assoc. of Queensland)	29	9	13	7	3				26		13	16		2		2			2	
"GLENLEIGHDON" (LANGUAGE & BEHAVIOUR THERAPY PROGRAM)	24		1	23		7			3	14	3	21		2	1		1	1		2 Parent Aides (18 chn. 6+)
KENMORE SOUTH SPECIAL PRE-SCHOOL UNIT	26	3	11	12		26					5	21		2	2	1	1	1		1 Phys.Ed.Teacher 1 Aide
MACKAY EARLY CHILDHOOD INTERVENTION PROGRAM	6	1	5		3	1		2				5	1		1		1		1	1 Adv.Teacher 1 Guidance Off.

QUEENSLAND - page 2

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
MT. GRAVATT SPECIAL PRE-SCHOOL UNIT	29	6	6	17		24			5		7	21	1	2	1			1		1 Adv.Teacher 1 Guidance Off.
NARBETHONG SPECIAL PRE-SCHOOL	37	6	20	11	2	9	22		2	1	20	13	4	2	1		1	1	1	(1 child not h/c.) (2 chn. 6+)
QUEENSLAND SUBNORMAL CHILDREN'S WELFARE ASSOCIATION (Infant Stim.Program)	101	21	56	24	4	84	2		11		31	66	4	3	2		3	6	2	
SPECIAL EDUCATION UNIT LEICHHARDT WARD STATE SCHOOL	7		3	4				4	3			7				1	2			(1 child 6+)
SPECIAL EDUCATION PRE-SCHOOL UNIT, YEERONGPILLY	47	4	26	17	1		43		3		1	26	20	7	2	1	2	1		1 Guidance Off.
TOWNVIEW SPECIAL EDUCATION UNIT	12			12		1		11				12		1	1	1	1			(10 chn. 6+)
W.R.BLACK HANDICAPPED CHILDREN'S CENTRE	50		8	42		33			17			15	35	4	2	1	1	1		(31 chn. 6+)

SOUTH AUSTRALIA : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
BRESLIE HOUSE DAY CARE CENTRE	21			21		21						21			1	4			1	1 Charge Nurse (16 chn. 6+)
DAY CARE CENTRE FOR TOTALLY DEPENDENT CHILD (KATE COCKS MEM.FAM.S.)	7	All under 6							7		2	5								2 F/time Staff Detail not stated
INFANT DEVELOPMENT PROJECT (FAMILY TRAINING UNIT)	5	5			2	3					5			1						
INTEGRATED PLAYGROUP MANSFIELD PARK JUNIOR PRIMARY SCHOOL	3		1	2	1	2						3			1			3		1 Charge Nurse
INTELLECTUALLY RETARDED SERVICES	122	69	35	18		122					85		37	1	5					4 Activity Advs. 4 Paramed Aides
KENT TOWN PRE-SCHOOL	30		11	19		30							30	3				1	1	5 School Aides
PORT PIRIE HANDICAPPED AND RETARDED CHILDREN'S CENTRE	12	1	6	5	3	5				1		8	4	1						1 Speech Aide Cons.:OT,Phys,ST (5 chn. 6+)
REGENCY PARK CENTRE FOR PHYSICALLY HANDICAPPED CHILDREN	34		17	17	21	1			3			25		3	4	1		1	1	1 Med.Officer 7 Aides (9 chn. not h/c)
SUNEDEN SCHOOL (MITCHELL PARK)	3[illegible]		2	36		36		2				38		4	3	1		1	1	(21 chn. 6+)
THE AUTISTIC CHILDREN'S CENTRE	21		2	19					9	12	1	20		3				2		(1 child 6+)
TOWNSEND PRE-SCHOOL FOR HEARING & HEARING IMPAIRED CHILDREN	53							11		1		53		6			1			1 Principal; 1 Visiting Teacher 2 Assistants (41 chn. not h/c.)
WHYALLA EARLY CHILDHOOD RESOURCE CENTRE	12	4	3	5	1	7			1	3	12			2						
WOODVILLE SPASTIC CENTRE	93	16	51	26	53	34	2		1	3		35	58	2	5	4	2	2	2	18 Aides

WESTERN AUSTRALIA : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Pysch.	Soc.Wk.	Other
CATHERINE McAULEY CENTRE	7		6	1		6				1		4	3			1				
CHILD DEVELOPMENT CENTRE, WEST PERTH (PHYSIO. GROUP)	42	25	23	4	39	2	1					42			2	2				Figures as given
CHILD DEVELOPMENT CENTRE, WEST PERTH (OCCUP. GROUP)	10		3	6			3			6		9				2	2	1		Figures as given
CHILD DEVELOPMENT CENTRE, WEST PERTH (PLAY AT HOME PROG.)	20	10	10							20	20					1				20 Child Health Nurses
CHILD STUDY CENTRE (UNIVERSITY OF W.A.)	14		7	7	2	5			1	6		14		2						1 Director, 1 Secretary, 1 Kindergarten Asst
HEARING ASSESSMENT CENTRE	36	3	10	23				34	2			36		6				1		2 Audiologists
"IRABEENA"	249	37	89	123	24	215			10		90	50	55		4	5	4	4	5	26 Soc.Trainers (20 chn. 6+) (20 chn. not h/c.)
PRESCHOOL, WHITE GUM VALLEY SP.SCHOOL	10		2	8		9							9	1						1 Aide (1 child not h/c.)
SPASTIC WELFARE ASSOC. OF W.A. (INC)	53	1	17	35	24	23			5	1		53		3	8	6	4	1		14 Training Assts (11 chn. 6+)
SUTHERLAND BLIND CENTRE (PRINCESS MARGARET HOSPITAL)	11		1	10			1		10			11		1						3 Teacher Aides (6 chn. 6+)
THE SPEECH & HEARING CENTRE FOR DEAF CHILDREN W.C. (INC)	15			15				15				15		5						2 Aides

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TASMANIA : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. chil-dren	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
AFTERNOON GROUP, LADY GOWRIE CHILD CENTRE	4		3	1						4		4		2				1		1 Nurse
BRUCE HAMILTON SCHOOL	8		2	6			6		2			8		1		1		1		(3 chn. 6+)
DOUGLAS PARKER REHABILITATION CENTRE	123	8	19	96	86	27	1	2	7			123			5	2	2		1	(79 chn. 6+)
KINDERGARTEN, LADY ROWALLAN SCHOOL, HOBART	14		9	5				10			4	10		1				1	1	(4 chn. not h/c.)
LANGUAGE INTERVENTION PROGRAM (EDUC), NORTHERN REGION (LAUNCESTON)	6		6							6		6					2			1 Speech Aide
LANGUAGE UNIT, LADY ROWALLAN SCHOOL, HOBART	6			6						6		6		1			1			1 Teacher Aide (3 chn. 6+)
MOTOR DEVELOPMENT PROGRAM (EDUC.DEPT)	11	4	5	2		10			1			11		2						1 Guidance Officer
PARENT-BABY GROUP, HEALTH, LAUNCESTON (ELONERA)	6	3	2	1		6					1	5				1		1		1 Med.Officer 1 Ind.Nurse 1 Mother Craft Nurse
QUINDALUP DAY TRAINING CENTRE, MENTAL HEALTH SERVICES (NEWTOWN)	26	0	4	22		9			17			26		1				1		(14 chn. 6+)
ST. MICHAEL'S SCHOOL (EDUC) LAUNCESTON	9		3	6						9		9		1			1			1 Aide (1 child 6+)
WARRANE KINDERGARTEN AFTERNOON GROUP	10		2	8		8				2		10		1						2 Teacher Aides

AUSTRALIAN CAPITAL TERRITORY : TABLE OF BASIC INFORMATION ON PROGRAMS

PROGRAM NAME	No. children	Age			Disabilities						Program			Staff (Full-time and Part-time)						
		0-2	2-4	4+	Phys.	Intell.	Vis.	Hear.	Mult.	Other	Home	Centre	H/C	Teacher	Physio.	O.T.	S.T.	Psych.	Soc.Wk.	Other
CRANLEIGH SCHOOL	16		1	15		12			4			16		3	2	2		1	1	3 Aides
DAVID ST. THERAPY CENTRE	123	70	53		60	26	5	5	27			123		1	5	1	1		3	1 Med.Supervisor 1 School Couns: 1 Ch.Hlth.Sister 1 Ch.Care Asst.
HARTLEY ST. CENTRE PRE-SCHOOL (TURNER PRIMARY SCHOOL)	14		8	6	12	2						14		1	4	2				1 School Couns: 2 Aides
MALKARA SCHOOL	14		1	13		14						14		2						1 Trained Nurse 3 Assistants

NORTHERN TERRITORY : TABLE OF BASIC INFORMATION ON PROGRAMS

DOWN'S SYNDROME ASSOC. OF NORTHERN TERRITORY	9		4	5		9					4	3				1	1			1 Adv.Teacher
STUART PARK SCHOOL	4	1	3					3	1			4		1						

APPENDIX K

STUDIES COMPLETED IN INFANCY RESEARCH FACILITY AT FRED AND ELEANOR SCHONELL EDUCATIONAL RESEARCH CENTRE

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HAYES, A.J. *Reciprocity in mother-infant interactions*. Paper presented to Society for Research in Child Development - Interdisciplinary Institute on the Origins and Growth of Communication, Univ. Delaware, U.S.A., June, 1979.

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HAYES, A.J. *Levels of description and explanation in studies of mother-infant engagement: On being appropriately indiscrete*. Symposium on Parent-Child Interaction and Parental Beliefs, Macquarie University, July, 1980.

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HAYES, A.J. Levels of description and explanation in studies of mother-infant engagement and interaction. In A. Nesdale, C. Pratt, R. Grieve, J. Field, D.J. Illingworth and I. Hogben (Eds), *Advances in child development: Theory and research.* Perth: University of Western Australia Press, 1981.

HAYES, A. and ELLIOTT, A.G.L. *Gaze and vocalization in mother-infant dyads: Conversation or coincidence.* Paper presented at the Biennial Meeting of the Society for Research in Child Development, San Francisco, March, 1979.

APPENDIX L

ANNUAL CENSUS OF PRESCHOOL AND CHILD CARE SERVICES : CHILDREN WITH SPECIAL DEVELOPMENTAL NEEDS(1)

The Office of Child Care, the Australian Bureau of Statistics (ABS) and responsible State and Territory administrative authorities have been developing for a number of years a national annual census of preschool and child care services. The first such collection was held in late 1980. All States and Territories were involved, except for Queensland where data were only collected from family day care schemes.

The census collects data on the staffing, operation and usage of all licensed and/or registered preschool and child care services. In relation to disabled children, data are collected on the number of regularly attending children who have any of the following special developmental needs :

1. Visually impaired child - A child who has been diagnosed by a professional worker such as a general practitioner or medical specialist (not a classroom teacher or child care worker) as having a visual impairment. Exclude any children whose vision is normal with glasses.

2. Hearing impaired child - A child who has been diagnosed by a professional worker such as a general practitioner or medical specialist (not a classroom teacher or child care worker) as having a hearing impairment. All children who wear hearing aids should be included.

3. Speech impaired child - A child who has been diagnosed by a professional worker such as a general practitioner or medical specialist or a speech therapist (not a classroom teacher or child care worker) as having a speech impairment.

4. Child impaired by a gross physical disability - A child who is impaired in mobility and/or manipulative skills because of a major physical disability. Examples of children in this category include children with spina bifida or cerebral palsy, children who were born without and/or who have lost limbs, and paraplegic children. This category does not include a child whose mobility and/or manipulative skills are impaired because of a learning disability or developmental delay. Do not include children with fractures.

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(1) Provided by the Office of Child Care, Canberra

5a. Developmentally delayed child - A child who has been diagnosed by a professional worker such as a psychiatrist, general practitioner or psychologist (not a classroom teacher or child care worker) as being developmentally delayed.

5b. Developmentally disabled child - A child who has been diagnosed by a professional worker such as a psychiatrist, general practitioner or psychologist (not a classroom teacher or child care worker) as being developmentally disabled (e.g. Down's syndrome children, hydrocephalic children).

6. Behaviourally disabled child - A child who has been diagnosed by a professional worker such as a psychiatrist, general practitioner or psychologist (not a classroom teacher or child care worker) as having a behavioural disability (e.g. a child who has been diagnosed as being hyperactive or autistic).

7. Multiply disabled child - A child with more than one of the special developmental needs 1 to 6, listed above.

8. Other referred child - A child who has been referred for care to this service by a professional worker such as a psychiatrist, general practitioner or social worker (not a classroom teacher or child care worker), or by a health and/or welfare agency, because of a special need (for example, an abused child), other than those listed above.

9. Child with a controlled condition - A child with an illness which whilst not causing a "handicap", does require special continuing treatment, e.g. diabetes, eczema, epilepsy and rheumatic fever.

10. All other children.

All of this data, except for data on children with controlled conditions, will be tabulated and should be available on request from the Office of Child Care and/or State/Territory authorities.

ABS will also be producing a document which summarises the national data (not including the information on special needs).

APPENDIX M

RECOMMENDATIONS FROM TWO ALLIED STUDIES

(A) Toy Libraries in Australia: A report with special attention to their role in services for young handicapped children and their families. Elkins, J., Calder, J., Conrad, L., Shepherd, J., Coulston, A., and Willis, M. Fred and Eleanor Schonell Educational Research Centre, University of Queensland.

1. Interrelatedness of Issues

A recurring theme in this report has been the complexity of issues associated with toy library operation, and the consequent interrelatedness of toy library functions with community variables. We wish to caution against the adoption of a single policy designed to operate in all settings. We therefore recommend that :

1.1 The legitimacy should be affirmed of different types of toy related services:

community toy libraries;

toy and recreation resources within education and/or therapy programs;

tertiary education linked toy libraries;

mobile and mail services.

It should be stressed that the appropriateness of each depends upon specific situational factors, the nature of related services, and identified needs.

1.2 Careful consideration should be given to the establishment of effective systems of communication to link community toy libraries with various networks serving children (especially the handicapped) and their families in areas of education, welfare, therapy and recreation.

1.3 Toy library policies for the future should be formulated in the light of the past contributions of the AATLH which has provided valuable assistance, particularly in:

its educative role in the broadest sense;

its linkage of toy libraries for the handicapped of various types with those for the wider community;

its provision of a common meeting ground for professionals, paid workers and volunteers.

1.4 Because of the initiative of personnel who have led in the establishment of toy libraries, there is evidence that the toy library could provide the nucleus for new service programs in the community (e.g. therapy, short stay residential services for handicapped children, camping). However, while an initiatory role is appropriate for community toy libraries they should endeavour to divest themselves of these additional functions as soon as the latter become self-sufficient.

2. Purpose and Function

Community toy libraries are a significant component of toy lending services in Australia. While toy resource units and toy libraries at tertiary institutions also play important roles for older children, it is our view that toy lending services to young handicapped children up to school age should be carried out predominantly through community toy libraries. We recommend that :

2.1 Community toy libraries should receive adequate support for their continued operation independent of other major service delivery systems for young handicapped children.

2.2 Community toy libraries should be developed only after careful planning to ensure their proper articulation with existing services in the surrounding community, and funding bodies should endeavour to ensure that appropriate prior study of needs takes place.

2.3 Special care should be taken so that the services provided by community toy libraries are properly articulated with services provided by other agencies to the same clients.

2.4 In the development of further community toy library services, the needs of handicapped children should be the first priority.

2.5 In order to equalize opportunity of access to toy library services, the establishment of toy libraries should be encouraged in those parts of Australia where deficiencies presently exist.

2.6 Wherever suitable, selected toy libraries might be supported to enable them to serve a co-ordinating function for a large region (or an entire state), and thereby assist in the establishment of new community toy libraries in outlying centres.

2.7 Consideration should be given to the designation of certain community toy libraries as demonstration centres in which staff in-service training can be carried out thereby promoting the further development of those toy library services which are newly established.

2.8 Notwithstanding our recommendation to establish further toy library services in regional centres, mobile and mail services should be developed to provide adequate services in different contexts, particularly in isolated rural areas.

2.9 The value of community toy libraries as neutral, non-threatening meeting places for families of handicapped children should be recognized and encouraged through funding for those aspects of community toy libraries operations which promote this end. Family support should continue to be an important function of toy libraries.

2.10 Primary responsibility for toy-lending and related services to handicapped clients up to the age of five or six years who have an identified or suspected handicap should be accepted by community toy libraries.

2.11 However, it is appropriate for community toy libraries to provide services to clients aged over six years, but the needs of such children for toys and educational materials should be met increasingly through units which are integral to other service delivery systems providing special education and/or therapy. Thus resource unit toy libraries and other educational materials resource facilities should be supported and established where these are presently failing to provide closely articulated services related to ongoing educational programming for handicapped children. Provision of toys is essential for children educated in integrated or mainstream settings as well as for those in special classes or schools.

2.12 Toy library services should not be extended to clients above an age limit deemed appropriate for toy use. Adolescent and adult clients risk devalued status through association with activities, such as playing with toys which are regarded as appropriate for younger clients. Older clients should be provided for by other more age appropriate resources such as community libraries and recreational services.

2.13 Educational and related services for handicapped children of school age should be funded at a level which permits them to provide appropriate toys and developmental materials for the adequate operation of their normal programs. Resource unit toy libraries might well be an integral part of such toy services, but community toy libraries should not play a major role, though they could provide specialist assistance, advise parents, and lend their specialized toys to individual families.

2.14 The name 'toy library' should be associated with community toy lending services and, to promote the normalization of service delivery to handicapped children, should wherever possible not have sub-titles indicating the clientele to be handicapped, even though this may be the case.

2.15 The extent to which educational, recreational, or therapeutic services are provided by community toy libraries should be carefully monitored by relevant advisory bodies. It is difficult to draw firm boundaries around the term 'therapy' where toy-related activities are concerned. However, programs conducted by community toy libraries should focus on parent involvement in their own child's development rather than intensive child-centred therapy.

2.16 In addition to carefully selecting toys for children according to developmental or therapeutic criteria, staff should ensure that client children are given the opportunity to choose for themselves modes of play and personal play-things, and should assist the development of self-initiated play.

2.17 Community toy libraries serving predominantly handicapped children should be supported in the practice of accepting some clients who are :

'at risk' children and those about whom concern is felt though no handicap has been confirmed;

siblings or friends of handicapped clients;

other children without handicaps.

Where pressure on toy library resources are such that restrictions are needed, handicapped children must be given priority in service delivery.

2.18 Where toy library services are offered to older children in educational and therapeutic programs, especially to children in full time residential care, these education/therapeutic programs should provide appropriate toys (and other related materials) needed for the operation of their programs, and for some of the home play needs of the clients. Community toy libraries should play only a supporting role in serving such clients.

3. Relationships with Other Services

Being a relatively new form of service to young handicapped children and their families, toy libraries need careful examination as to the nature and extent of their relationships with existing and emerging services, particularly among the latter, early intervention programs. We recommend:

3.1 Judgements about the operation of any one toy library should take into account its relationship with other relevant services for children.

3.2 Both formal and informal interactions should be encouraged between toy library services and relevant professional organizations, especially as the nature and training of toy library staff are further expanded.

3.3 Toy libraries should have access to the services provided by T.A.D. (design and construction of non-standard aids including toys for disabled children and their families). T.A.D. groups currently exist in N.S.W., Victoria, Tasmania and South Australia. A recent Children's Services Program grant will allow for the formation of such groups throughout Australia.

3.4 As the nature of toy library services and the type and extent of their co-ordination will vary with local context, studies, including needs assessment, should be carried out to determine appropriate patterns of service provision.

3.5 Staffing of toy libraries should be tailored to the range and types of services provided.

3.6 Efforts should be made to upgrade the theoretical and practical proficiency of toy library staff in matters germane to toy library operation.

3.7 Aspects of counselling and interviewing which will assist toy library staff in their work with parents of young handicapped children should be included in training programs.

3.8 Training opportunities should be developed at different levels in order to cater for the needs of different types of staff - professional, para-professional, and volunteer.

3.9 A small number of large toy libraries might be assisted to develop, in association with AATLH, procedures for in-service training programs for staff. Involvement of staff in such training programs should occur as soon as possible after the commencement of work in a toy library service.

3.10 Support should be given to encourage the continuation and further development of current work being done by AATLH and CAE's in the areas of in-service training, conferences, workshops for country personnel, and training courses. Attention should also be given within such schemes for the provision of 'apprenticeship' opportunities in which trainee staff work under supervision of accredited major toy libraries.

3.11 Existing specialist toy libraries in which staff exhibit great expertise in some aspect of toy library operation should receive support to facilitate a leadership role at regional, state and national level. Thus some, but not many, toy libraries might be located at, or linked with, tertiary institutions involved in professional training in areas associated with handicapped children. Others might develop special correspondence materials on play and toy use for isolated parents.

3.12 Consideration should be given to the establishment of a national advisory panel on toy library services. An advisory panel requires representation from:

AATLH;

library services;

recreation services;

handicapped children's services;

family welfare services.

3.13 Professionals from various disciplines also need to be involved in assisting the advisory panel, including:

early childhood educators;

therapists - physical, occupational and speech;

play and recreation specialists;

psychologists;

special educators;

social workers.

Parents should also be given an opportunity to provide information and views to the panel.

3.14 The present study needs to be supplemented by the monitoring activity of such an advisory panel which should periodically examine the concept and operation of toy library services and give special attention to the needs of young handicapped children and their families within such services.

4. Funding

Because of the relatively short period during which toy library services have been in operation, there are not as yet established sources of funding. The past few years have been characterized by toy libraries seeking funds wherever it was thought likely that support might be forthcoming. Toy libraries on establishment have received assistance from a variety of sources, but the ongoing maintenance of services appears to need some long-term commitment from public funding. Also important is the recognition of the principle that parents of handicapped children should not have greater expenses in meeting their children's needs than those experienced by parents in general.

4.1 Criteria which should be assessed for public funding of toy library services should include:

assessment of need (community, clientele);

quality of primary service dimensions (toys, site, staff);

quality of secondary services, if any;

extent of service (area or region, numbers of clients);

types of program elements;

staffing characteristics;

likely impact of establishment of service on community;

including additional demands which may be generated;

relationships with existing services.

4.2 A problem not confined to toy libraries concerns the roles of 'seeding' grants and long-term funding. Clarification is needed of the proper role of various government departments in the funding of toy library services.

4.3 The value of local support and participation in funding of toy library services is recognized but substantial government assistance is also needed. Consideration should be given to ways in which stability of government funding can be achieved for toy libraries which serve handicapped children.

4.4 Maintenance of public expenditure demands accountability and procedures for evaluating toy library services should be established.

4.5 For the immediate future, consideration might be given to the Office of Child Care providing major support of community toy libraries and those components of other services such as resource units and tertiary affiliated facilities which serve a similar function.

4.6 It is important that other appropriate commonwealth and state instrumentalities fund the purchase and distribution of toys and other developmental and recreational equipment as part of their general funding to services for children, especially the handicapped. However, increases in funding of other resources should not diminish the level of funding for the operation of community toy libraries. Funding is presently not at a level that permits effective implementation of even the restricted range of services we have recommended as the priorities of toy libraries. Many staff are working at salaries below their professional entitlement.

5. Research and Development

The complexity of play behaviour and its subtle interweaving through the course of children's development are such that our present knowledge is notable for the extent of the unanswered questions. There is a strong intuitive base for much of present toy library practice, but a better service could be provided if more were known about play, especially its significance for the optimal development of handicapped children. We recommend:

5.1 That basic and applied research on aspects of toy use and play behaviour in young handicapped children be supported by research funding agencies such as ARGC and ERDC.

5.2 That evaluations be carried out of mobile and mail toy library services.

5.3 That support be provided for the production of audio-visual and printed materials which may be used in public education and dissemination of information about toy use, play behaviour and toy library services. The important initiatives already taken by Noah's Ark Toy Library, Melbourne, and by the AATLH are to be commended.

6. Principles Underlying Toy Library Services

It is important to recognize certain underlying principles and values which we consider to be crucial to the development of effective toy library services. The complexity of the issues discussed in this report makes it vital that certain fundamental ideas be affirmed to offer guidance in decision making about toy library services. We recommend:

6.1 Toy libraries should be established and operated so that handicapped clients and families are served in as normalizing a manner as possible.

6.2 There should be regular evaluation (both internal and external) of toy library services.

6.3 Child-initiated play behaviour should be ensured within the context of the necessary emphasis on guided developmental and therapeutic toy services which toy libraries offer.

6.4 Co-ordination and articulation of related services with toy libraries are of great importance. Regional committees should be formed to promote and monitor these aspects of service provision.

6.5 Inasmuch as toy libraries serve families as well as children, the value of a transactional mode of operation should be stressed in which family needs are recognised in the delivery of services to handicapped children within the family. Such family needs include information, book lending, help for siblings as well as general family support and counselling.

(B) Special Preschools : Monitoring a Pilot Project. Hayes, A., Steinberg, M., Cooksley, E., Jobling, A., Best, D., and Coulston, A. Fred and Eleanor Schonell Educational Research Centre, Brisbane, 1980. (Draft report)

The recommendations in this report on the monitoring of pilot early educational intervention programs by the Department of Education in Queensland refer to five distinct areas :

Contextual Issues

Program Developments

Support Services

Programs Beyond the Special Preschools

General Directions for the Future Development of Early Educational Intervention Programs

1. Contextual Issues

1.1 Family characteristics and access

- Trained specialist personnel should be available to assess family needs, family resources to support their handicapped child, and aspects of the family context that may be relevant to the early educational intervention program. The skills of social workers are most appropriate to these tasks.

- A survey of the extent of awareness of the existence and nature of early educational intervention programs should be conducted among families, schools, medical practitioners, and other service delivery professionals in the catchment area for any existing or projected special preschool.

- Special preschools should be located as close as possible to public transport, with easy access from the street to the unit and, wherever possible, in close proximity to other relevant services.

- The teachers in special preschools should be explicitly prepared for their role as information resource persons for parents.

1.2 The characteristics of the children requiring early educational intervention programs

- Initial assessment of children should be undertaken on entry, or soon after entry, to the special preschool.

- Such assessment should include educational, psychological, language, motor, and medical components, and any other areas required to give a comprehensive picture of a particular child's developmental status.

- The aim of such an assessment should be to provide information relevant to the design and implementation of the intervention program.

- The child's developmental characteristics should be viewed against the background of an assessment of the home and family context, ideally by a social worker.

1.3 Assessment, record keeping and information exchange

- Increased numbers of personnel should be provided as a matter of urgency to agencies screening and assessing young children with a view to placement in early educational intervention programs.

- The training of educational, psychological, therapy, social work and medical professionals to work in early intervention should provide basic preparation in the screening and assessment of very young children.

- The agencies employing such professionals should facilitate the emergence of specialists in the area of developmental assessment of young handicapped children in order to form an assessment nucleus in each region served by the agency.

- Mechanisms should be explored to ensure the efficient assessment of all children requiring such services, and the co-ordination of agency personnel to achieve this end.

- Assessment information should always be recorded in an efficiently transportable form to provide access to information by all the professionals needing it.

- The training and functioning of professionals should underscore the need for communication of information in a form and language that crosses the disciplinary boundaries and wherever possible avoids the use of jargon.

- Efficient mechanisms for case co-ordination and multidisciplinary consultation on particular children need to be established, and effective networks of information exchange formed among the agencies and professionals involved with children attending special preschools.

- There should be explicit policies ensuring ongoing assessment and periodic review of placement for all children in early educational intervention programs.

- Skilled support staff should be appointed to ensure efficient information storage retrieval and exchange.

- All agencies should explore the formulation of policies and the establishment of procedures to enable parents to have access to their children's assessment records, should they so desire.

2. Program Development

2.1 Teacher philosophies and roles

- Ongoing discussions should be held at both the policy making and program implementation levels to crystallize an overall philosophy of early educational intervention that can be adapted to the range of client needs.

- The teachers' role in early educational intervention should be re-considered to allow rational use of time for both unit based programming and home based, parent support activities. This may necessitate increased involvement of aides and volunteers in program implementation.

- The preparation of teachers for work in special preschools should include training in basic crisis counselling skills and sufficient knowledge of the counselling service delivery system to be able to make appropriate referrals.

- An explicit policy should be formulated on the provision of a Departmental officer in each region as the identifiable support and advisory person for the special preschools.

- The nature and function of home based services in early educational intervention should be investigated with a view to improving this aspect of the service. Particular attention should focus on ways of enabling the teacher to provide an adequate home visiting service, given the serious constraints on staffing.

- The training of teachers to operate special preschools should emphasize the acquisition of knowledge of both normal and exceptional developmental patterns in infancy and early childhood.

2.2 Program development and implementation

- There is an urgent need for collaboration between the Divisions of Preschool Education and Special Education. Structures should be established for consultation and collaborative program development. Kindergarten organizations and other agencies should also be involved in these processes of collaboration.

- Regular and Special Preschool program staff should be involved in periodic exchanges to enable both groups to become more aware of the particular needs of the other's clientele.

- Systems for detailed program record keeping should again be investigated as a matter of urgency; again, ways of ensuring that teachers have sufficient time for this activity should be considered.

- Wherever possible, the other professionals involved with the children's development should be included in the process of program formulation.
- Program record keeping and evaluation should be seen as part of the ongoing assessment of the children.
- The feasibility of summarizing program records in a form that allows access and transmission to other professionals and parents, should be considered.

2.3 Parents and programming

- In principle, parents should be directly involved in their child's program wherever possible. Careful consideration, however, should be given to the wishes and resources of families before they are involved. The services of a social worker could be utilized in this area.
- Any program implemented by a parent should be carefully monitored to ensure that parents are coping and where necessary additional support should be provided to facilitate implementation.
- Appropriate staff should be trained to offer behavioural management programs for those parents desiring assistance in handling their handicapped children.

3. Support Services

3.1 The availability, training and functions of support personnel: guidance officers, school medical officers, paediatricians, speech therapists, occupational therapists, physiotherapists and social workers.

- There should be a general review of policies concerning the availability of guidance officers, school medical officers, therapists and social workers to support early educational intervention programs.
- Wherever possible, mechanisms should be developed for better co-ordination of support service delivery, including networks of information exchange.

- Awareness of developments in the field of early educational intervention should be fostered in each of the disciplines likely to be involved in providing support services to special preschools. This implies the need for revision of some of the content of training programs.
- Guidance officers should be enabled to devote greater time to early educational intervention programs and to act as co-ordinators of information.
- Advisory teachers should be employed in part to assist the guidance officers with collection of assessment information.

3.2 Team approaches to the delivery of support services.

- Discussions should be held by agencies and professional associations to explore workable solutions to the problems impeding team functioning in the delivery of support services to the special preschools.
- Each discipline should review its traditional role definition in order to delineate where its professionals could offer consultancy services.
- Training institutions should explore ways of including multi, inter and transdisciplinary team experience in the training of students in guidance, educational psychology, medicine, the therapies, and social work.
- Issues of information exchange, team leadership, and case conferences should be explicitly considered by both policy makers and educators.

4. Programs Beyond the Special Preschools

4.1 Integration

- Integration of exceptional children into regular educational settings should be carefully monitored and regularly reviewed.
- There should be a link person, such as a special preschool advisor, to liaise with staff in the regular and special preschools.

- It should be ensured that the specialist support staff required by the child are available to deliver services in the regular setting, should this become the child's primary placement.

4.2 The special preschools as clearinghouses

- There should be careful consideration of the links between the special preschools and other educational placements for children who have been in early educational intervention programs.
- Longitudinal follow-ups should be undertaken to evaluate the articulation of special preschools with other placement options, and to assess the efficacy of special preschools as early educational clearinghouses.
- The needs of children in later placements should be surveyed with a view to assessing the adequacy of support services.
- Guidance officers should be involved in overseeing the transition of children from special preschools to their next placement and in undertaking the process of periodic review of the placement.
- Better networks of communication among the various sectors of education in Queensland accepting children from special preschools may have to be established.

5. General Directions for the Future Development of Early Educational Intervention Programs

5.1 Co-ordination

- Explicit policies should be developed to facilitate co-ordination of early intervention services both within agencies and among agencies, at local, regional and state levels.
- The development and functioning of the regional "core" committees should be monitored with a view to identifying those factors which contribute to successful co-ordination, and those which impede progress, at a regional level.

5.2 Beyond the first pilot phase

- The Standing Committee on Early Intervention should be responsible for the further monitoring of the development of special preschool programs.
- A second pilot phase should be undertaken, on a limited scale, in a selection of provincial centres, before a decision is taken to establish special preschools throughout the state.
- The wider establishment of special preschools should be the subject of recommendation by the regional committees following a thorough survey of needs and resources.

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